Jurupa Unified School District
Head Start/State Preschool/Title I
2018-2019

Initial Eligibility Certification Requirements

In order for your child to be certified, you will need to bring the following:

1. **Birth Certificate (child MUST be 3 years old on or by registration appointment)**
2. **Income verification (must meet Federal and State Income Guidelines for 2018/2019 school year)**
   Income is **gross** income (before deductions) from all sources, including public assistance. Family income **will be** verified when the family brings in proof of the following:
   - W2 or Federal Tax Return (2017) and 4 most recent paystubs with a year-to-date amount
   - Release of Employment form completed by employer stating amount of pay, pay periods and length of employment
   - Passport to Services document from Department of Public Social Services
   - Disability, Unemployment, or Worker's Compensation verification
   - Alimony or Child Support – can be obtained online (www.childsup.ca.gov) or from Child Support Services, 2041 Iowa Ave., Riverside, CA (proof required at registration)
   - Commissions, Bonuses, Dividends, Interest, or Pensions
   - Social Security payments verification
   - Verification of Self-Employment including Profit and Loss statements for last 3 months, business card and/or flyer
3. **Documentation and Verification of Family Size**
   One of the following documents must be provided for **each child** listed as part of the family size:
   - Birth certificate
   - Child custody court order (required if applicable)
   - School or medical records
   - County welfare records
   - Reliable documentation showing relationship to parent

   If only one parent is listed on the application and the birth certificate indicates the child has another parent whose name does not appear on the application the following documentation must be provided:
   - Records of divorce or legal separation
   - Evidence that the parent on the application is receiving child support, has filed for child support, or executed documents declining to file
4. **Proof of address** (any evidence of a street address in California in which the enrolling child resides)
5. **Immunization record** (most up-to-date shot record)
6. **Physical examination** with TB Risk Assessment screening within the last 12 months is required. A blood test to screen for anemia and lead level results are **also required**.

***Priority is given to four-year-old children residing within the Jurupa Unified School District boundaries.**
***Transportation is NOT provided.**
***Head Start/State Preschool/Title I Programs are a part-day and full-day educational program for low-income families and serves children with disabilities.**

FOR MORE INFORMATION, CONTACT (951) 222-7850

(Revised 03/18 JM)

Jurupa Unified School District
Head Start/State Preschool/Title 1

CONFIDENTIAL INTAKE APPLICATION

Complete using **BLACK** ink only
PLEASE PRINT

CONFIDENTIALITY STATEMENT: Information shared with the staff will be kept strictly confidential, unless its release is authorized in writing by the parent(s)/guardian(s). These forms will be kept in locked files.

CHILD'S INFORMATION

Last Name		**First Name**	
Date of Birth	**Place of Birth (City & State)**		**Sex**
Address	**Apt.**	**City**	**State**
Mailing Address (if different)	**Phone Number** ( )		**Hispanic/Latino?** ☐ Y ☐N

Race ☐American Indian/Alaskan Native ☐Black/African American ☐Pacific Islander ☐Asian ☐Caucasian

CHILD'S HEALTH INFORMATION

Does your child have health insurance? ☐Y ☐N

Type of Insurance:	**Doctor/Clinic:**	
Address	**City**	**Phone** ( )

Health problems/concerns:

CHILD'S DENTAL INFORMATION

Does your child have dental insurance? ☐Y ☐N	**Dentist/Clinic:**	
Address	**City**	**Phone** ( )

Dental problems/concerns:

CHILD'S SPECIAL NEEDS INFORMATION

Does your child have a special need? ☐Y ☐N

If yes, do you have documentation of the child's special need? ☐Y ☐N

Which of the following describes your child's special need?

☐Speech/Language ☐Hearing/Deaf ☐Vision/Blind ☐Intellectual Disability
☐Health Disability ☐Orthopedic ☐Learning ☐Autism
☐Other/Describe:

FAMILY INFORMATION

Family size*: _____ **Children ages 0-3:** _____ **Status:** ☐One Parent ☐Two Parent

**Parents/guardians of the enrolling child and siblings under the age of 18.*

Head of Household	**Relationship to Child**
☐Father ☐Mother ☐Guardian	☐Natural/adopted/step ☐Foster ☐Grandchild
☐Grandparent ☐Other:	☐Niece/nephew ☐Other:

Is the family receiving:

☐CalFresh CF#: _____ **☐WIC WIC ID:** _____

I would like to receive information in: ☐English ☐Spanish

PARENT/GUARDIAN 1

Full Name	**Hispanic/Latino?** ☐Y ☐N	**Date of Birth**	**Age**

Race ☐American Indian/Alaskan Native ☐Black/African American ☐Pacific Islander ☐Asian ☐Caucasian

Education

☐Grade 9 or less ☐Grade 10 ☐Grade 11 ☐Grade 12 ☐GED ☐High School Grad

☐Some College ☐Advanced Training ☐Training Certificate ☐AA ☐BA/BS ☐Master's Degree

Employment Status

☐Full-time & Training ☐Full-time (35hrs or more) ☐Part-time & Training ☐Part-time (35hrs or less)

☐Retired/Disabled ☐Seasonally Employed ☐Training or School ☐Not Employed

Income Source (check all that apply)

☐Wages ☐Cash Aid ☐Child Support ☐Disability/Worker's Comp. ☐Self Employed

☐Social Security ☐Unemployment ☐Foster Reimbursement ☐Other:

Phone Number	**Email**	**Receive text/email notifications**
( )		☐Y ☐N

PARENT/GUARDIAN 2

Full Name	**Hispanic/Latino?** ☐Y ☐N	**Date of Birth**	**Age**

Race ☐American Indian/Alaskan Native ☐Black/African American ☐Pacific Islander ☐Asian ☐Caucasian

Education

☐Grade 9 or less ☐Grade 10 ☐Grade 11 ☐Grade 12 ☐GED ☐High School Grad

☐Some College ☐Advanced Training ☐Training Certificate ☐AA ☐BA/BS ☐Master's Degree

Employment Status

☐Full-time & Training ☐Full-time (35hrs or more) ☐Part-time & Training ☐Part-time (35hrs or less)

☐Retired/Disabled ☐Seasonally Employed ☐Training or School ☐Not Employed

Income Source (check all that apply)

☐Wages ☐Cash Aid ☐Child Support ☐Disability/Worker's Comp. ☐Self Employed

☐Social Security ☐Unemployment ☐Foster Reimbursement ☐Other:

Phone Number	**Email**	**Receive text/email notifications**
( )		☐Y ☐N

SIBLINGS RESIDING IN THE HOME

Name	Relationship to Enrolling Child	DOB	Sex	Hispanic/ Latino Y/N	Race

Race Key **AI/AN** - American Indian/Alaskan Native **B** - Black/African American **PI** - Pacific Islander
A - Asian **C** - Caucasian

OTHER ADULTS LIVING IN THE HOME

Name	Relationship to Enrolling Child	DOB	Contributing to household income?
			☐ Y ☐N
			☐Y ☐N
			☐Y ☐N
			☐Y ☐N
			☐Y ☐N

I verify that all the information provided on this INTAKE APPLICATION is true and correct.

Parent/Guardian Name	Signature	Date

Physical Examination

Child's Name: _____ Date of Physical Examination: _____

Date of Birth: _____

Head Start requires a complete CHDP equivalent health examination for entrance into the program.

CHDP Periodicity visit for:	24 Mos	30 Mos	3 Yrs	4 Yrs	5 Yrs

TB Risk Factor Assessment:	Blood Lead Risk Factor Assessment:
❑ Risk factors not present; TB skin test not required	❑ Risk factors not present ❑ Risk factors present

Hematocrit /Hemoglobin 9 Month 2,3,4 Years	Date:	Results:	Anemia: ❑ Yes ❑ No	Iron Supplements: ❑ Yes ❑ No	
Blood Lead Test: 12 and 24 Month If no record, perform	Date:	Results:	Blood Pressure:	Date:	Results:____ / ____
Tuberculin Skin Test	Date Given:	Date Read:	Results: ☐ Negative ☐ Positive	Chest X-ray Date:	Results: ☐ Negative ☐ Positive
Height: (%)	Weight: (%)	BMI:		Head Circumference:	
Vision: Right – 20/_____	Left – 20/ _____	Strabismus: ❑ Pass ❑ Fail		Hearing: ❑ Pass ❑ Fail	

Examination Results	Normal for age	Abnormal (Describe Findings)	Not Tested	Examination Results	Normal for age	Abnormal (Describe Findings)	Not Tested
Anticipatory Guidance				Eyes/Vision Observation			
Posture, Gait				Ears/Clinic Assessment			
Birth Defects				Developmental Screening			
Ears/Nose/Throat				Autism Spectrum Disorder Screening			
Seizures				Developmental Surveillance			
Mouth/Teeth Dental/Nutrition				Psychosocial/Behavior Assessment			
Heart/Lungs				Communication Skills/Speech			
Asthma				Cognitive Skills			
Abdomen (Hernia)				Maternal Depression Screening			

Is the child cleared to enter preschool? ❑ Yes ❑ No

List any allergies, chronic conditions or special accommodations: _____

_____

List medications required at school (include medication name and dosage): _____

_____

Provider (Please print): _____ Signature: _____

Practice/Clinic Name: _____ Phone Number: _____

Address: _____

JURUPA UNIFIED SCHOOL DISTRICT
Head Start/State Preschool

RELEASE OF EMPLOYMENT INFORMATION

Jurupa Unified School District Head Start/State Preschool program may provide services to the child of the parent listed below. In order to document eligibility, we are required to obtain the following information from the employer:

TO BE COMPLETED BY PARENT:

I, _____, hereby give authorization for the below listed employer to provide Jurupa Unified School District with the employment information.

_____ _____
Parent's Signature Date

TO BE COMPLETED BY EMPLOYER:

Employer's Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Hours of Operation: _____

This is to certify that _____ is employed by

_____. Starting date of employment: _____.

Employee is: ☐ A salaried employee: $ _____ Paid: ☐ weekly ☐ bi-weekly ☐ semi-weekly ☐ monthly

Employee is: ☐ An hourly employee: Hourly rate: $ _____

Paid: ☐ weekly ☐ bi-weekly ☐ semi-weekly ☐ monthly

Employee is: Paid cash – Amount $ _____ Paid: ☐ weekly ☐ bi-weekly ☐ semi-weekly ☐ monthly

Employee is: ☐ Part Time Hours per Week _____ ☐ Full Time Hours per Week _____

Does employee receive: ☐ Tips $_____ ☐ Commission _____ ☐ Overtime Pay $ _____

Paid: ☐ weekly ☐ bi-weekly ☐ semi-weekly ☐ monthly

Signature of Employer: _____ Date: _____

FOR OFFICE USE ONLY: Verified by: _____ Date: _____ Position: _____

(Revised 03/18 JM)

Family Needs Assessment

___ Initial
___ 1st Conference
___ 2nd Conference

Child's Name: _____ Site: _____ Session: ___AM ___PM ___FD

Parent Name: _____ Date: _____

We are here to assist you with information, resources, referrals, and opportunities for training. Please let us know how we can support your needs and interests.

Do you have any EMERGENCY or need any immediate crisis assistance in the following areas?

- ❑ Food
- ❑ Shelter
- ❑ Domestic Violence
- ❑ **None at this time**
- ❑ Other: _____
- ❑ Clothing
- ❑ Counseling
- ❑ Child Abuse
- ❑ Utilities Assistance
- ❑ Health Concerns
- ❑ Alcohol/Drug Abuse

Family and Personal Needs (Do you need any of the following?):

- ❑ Health Care Access/Health Insurance
- ❑ Child Support Assistance
- ❑ Childcare Services
- ❑ Low Cost Legal Services
- ❑ Nutrition/Physical Activity
- ❑ Foster Care Resources
- ❑ Father Engagement
- ❑ Goal Setting
- ❑ Computer Skills
- ❑ Adult Literacy Programs
- ❑ English as a Second Language (ESL)
- ❑ Stress Management
- ❑ Marriage Education
- ❑ Dental Education
- ❑ Other: _____
- ❑ Food Programs (Food Stamps/WIC)
- ❑ Budgeting/Savings
- ❑ Counseling/Support Groups
- ❑ Guardianship Assistance
- ❑ Health Education/Health Concerns
- ❑ Parenting Skills and Education
- ❑ Positive Discipline
- ❑ Employment Resources
- ❑ Senior Support Services
- ❑ Anger Management
- ❑ Financial Education
- ❑ Utilities Assistance (non emergency)
- ❑ **None at this time**
- ❑ Public Assistance (Cash Aid/SSI)
- ❑ Disability Services
- ❑ Low Cost Housing
- ❑ Assistance to Families of Incarcerated
- ❑ Emergency Preparedness
- ❑ Immigration Assistance
- ❑ Pregnancy Education/Postpartum Support
- ❑ Continuing Education (High School Diploma, GED, College, Career Technical Education)
- ❑ Alcohol/Drug Prevention
- ❑ Income Tax Services
- ❑ Veteran Resources
- ❑ Clothing/Food assistance (non emergency)

Community Services (Do you need any of the following?):

- ❑ Utility Programs
- ❑ Community Activities
- ❑ Local Community Resources
- ❑ **None at this time**
- ❑ Other: _____
- ❑ Library Programs
- ❑ Senior Activities
- ❑ Public Transportation
- ❑ Volunteer Opportunities

Children Needs (Do you need any of the following?):

- ❑ Child Development Milestones
- ❑ Tutoring
- ❑ Disability Support
- ❑ Other: _____
- ❑ Activities for Home Learning
- ❑ After School Programs
- ❑ Child's Health and Well-being
- ❑ Child Safety
- ❑ Youth Programs
- ❑ **None at this time**

Staff Use Only

Date Reviewed: _____ Needs Identified: ❑Yes ❑No Resources Provided: ❑Yes ❑No Staff Initials: _____

Comments: _____

_____

_____

_____

_____

(Revised 10/11/17 CH)

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

Centralized Complaint and Information Bureau

ADDRESS

744 P Street

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Sacramento	95814	(844) 538-8766

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)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

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

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

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

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Centralized Complaint and Information Bureau

   Licensing Office Address: 744 P Street, Sacramento, CA 95814

   Licensing Office Telephone #: (844) 538-8766

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

8. Receive, from the licensee, the Caregiver Background Check Process form.

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

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

LIC 995 (9/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

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

_____
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

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

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

Jurupa Unified School District

SCHOOL READINESS CENTER
5960 Mustang Lane, Jurupa Valley, CA 92509
Telephone (951) 222-7850 Fax (951) 222-7853

Release of Information

I, _____, hereby authorize the Jurupa Unified School District, Head Start/State Preschool/Title I Program, Riverside County Office of Education (RCOE), Children's Services Unit (CSU); to verify any information utilized to determine my family's eligibility and/or need during the time that I am enrolled in the subsidized child care program.

I understand that the means of verification may include:

- The sharing of information between agencies to verify my income, eligibility, and need for child care and/or support services. Agencies that may be contacted include, but are not limited to, the Department of Public Social Services, Department of Child Support Services, Housing Authority, First 5 Riverside, Riverside County Child Care Consortium, training sites/schools, social service agencies, referring physicians, emergency shelters, and employers/clients.
- Review of information via other resources to include, but not limited to: online employment verification sites, social networking sites, searches through online search engines, address verifications through online mapping, and review of court or law enforcement databases.

I give my permission to the JUSD Preschool Program and CSU to request from and/or provide to other publicly-funded agencies any eligibility and/or need information required to ensure proper use of State/Federal funds.

I understand that if the information provided to the JUSD Preschool Program and CSU to establish initial and on-going eligibility is found to be fraudulent and/or deceitful, my child care services will be terminated and I will be responsible for repayment to the JUSD Preschool Program and CSU for any child care benefits paid on my behalf to which I was not entitled to. I further understand that providing fraudulent and/or deceitful information may forfeit my rights to any future child care services and will be forwarded to the appropriate state or federal agency.

_____	_____	_____
Print Name (Parent/Guardian 1)	Sign	Date
_____	_____	_____
Print Name (Parent/Guardian 2)	Sign	Date

<u>Must be signed by both parents/guardians</u>

(Rev. 4/10/17 JM)

Jurupa Unified School District
Head Start/State Preschool/Title I

PHOTOGRAPHIC AGREEMENT

Pictures or videos of classroom activities may be taken to share with other children, teachers, and/or parents. Pictures and video will be used primarily by the JUSD Preschool Program staff for classroom displays, as a tool to improve instructional skills, and for training purposes. Photographs and/or videos will **not** be shared or uploaded onto any public website or social media application.

I understand my child, _____ may be photographed/videotaped while involved in this program.

_____ _____

Parent/Legal Guardian Signature Date

(Rev. 3/28/18 CH)

Jurupa Unified School District
Head Start/State Preschool/Title I

Parent/Guardian Agreement

The Head Start/State Preschool/Title 1 Preschool Program wants to welcome you. We provide comprehensive child development programs which not only meet the educational needs of preschool children but also meets their health, nutrition, mental health, and social service needs as well. Our staff believes that parents/guardians are the most important influence on their children and see the meeting of your child's needs as a joint responsibility between parents/guardians and staff. Parents/guardians are encouraged to collaborate with staff in the delivery of the full range of program services available to families.

The Department of Social Services, Community Care Licensing Division shall have inspection authority as specified in the California Health and Safety Code Sections 1596.852 and 1596.853. The Health and Safety Code sections 1596.852 and 1596.853 provide the authority for Community Care Licensing representatives to access the Center to determine ongoing compliance with Community Care Licensing regulations, to conduct announced and unannounced visits to the Center to investigate all oral and written complaints, to review child and program records, to conduct inspection of the children, and to conduct private interviews with the children. All licensing reports are maintained on site and are available for public review.

When you enroll your child in a Head Start/State Preschool/Title 1 preschool program you agree to accept the basic services that are provided.

1. The law states that child care workers are mandated reporters. Withholding treatment and endangering the health or safety of the child is a violation of California law and must be reported to a Child Protection Agency.
2. The staff uses classroom management techniques which do not include physical or verbal punishment. Physical or verbal punishment of children while under our care is forbidden by both state and local policies. Also, while the child is under staff supervision, parents must not physically or verbally punish their own children or other children in the program.
3. You are encouraged to provide input in all areas of the program.
4. Children who are enrolled are expected to be in regular attendance at school. Excessive absences may result in your child being dropped from the program.
5. Mental health services may be offered to support your child's well-being through collaboration with district and community partners.
6. The Preschool Program welcomes children with special needs and believes in providing an enriched preschool environment for all children. The program collaborates with parents and the appropriate local education agencies to both monitor and support the growth and development of children identified with disabilities or who are found eligible to receive specialized services.

I understand my responsibilities.

_____ _____

Signature – Parent/Guardian Date

_____ _____

Child's Name Site

Distrito Escolar Unificado de Jurupa
Head Start/Preescolar Estatal/Título 1

Late Drop Off/Late Pick-Up Policy

One of the objectives of the Head Start/State Preschool/Title I Preschool Program is to provide an environment that is safe and conducive to the development of each child's growth and development.

There are specific rules and procedures regarding late drop off/late pick-up of children in the program.

The Late Drop Off and Late Pick-Up Policies are:

1. A parent or other designated adult over 18 years of age is expected to drop off and pick-up their children promptly at the beginning and end of class.
2. When a child is dropped off or picked-up late, a late drop off/late pick-up notice will be issued.
3. After three "Late Drop Off/Late Pick-Up" notices have been given, a conference will be scheduled with the teacher. The conference will include a review of the Late Drop Off/Late Pick-Up Policy and update the family's emergency card.
4. If three more "Late Drop Off/Late Pick-Up" notices are issued, a conference with a supervisor will be scheduled. Excessive tardiness will result in the re-evaluation of your family's need for continued program services and your child may be terminated from the program. If the child is dropped, the family will have the opportunity to reapply and may be placed on the waitlist.
5. In the event that a child is not picked up by 30 minutes after the end of class, and all attempts of contact have been made to reach the parent/guardian or other emergency designee, this will constitute an "emergency situation." The supervisor will take steps to assure the safety of the child which may include contact with the local police department and/or Child Protective Services (CPS). The incident will be documented and the parent will be required to meet with the supervisor.
6. Every effort will be made by the site to assure the fair and expedient implementation of this policy.

I, _____, have received, understand, and will comply with the Late Drop Off/Late Pick-Up Policies of the Head Start/State Preschool/Title I Preschool Program.

_____ _____
Parent/Guardian Signature Date

_____
Child's Name

JURUPA UNIFIED SCHOOL DISTRICT
HEAD START/STATE PRESCHOOL/TITLE I

ILLNESS AND EXCLUSION POLICY – CHILD

The Head Start/State Preschool/Title I Child Illness and Exclusion Policy goals are that each child entering the classroom is able to comfortably participate in daily activities and to prevent the spread of communicable diseases among children. Staff will make the final decision about whether children who are ill may attend. The decision will be based on the program's inclusion/exclusion criteria and the staff's ability to care for the child who is ill without compromising the care of other children in the program. The parent, legal guardian, or other person authorized by the parent/guardian shall be notified immediately when a child has signs or symptoms requiring exclusion from the facility, as described below. Families should have emergency plans in place for children that have been excluded from classroom participation due to illness.

A) The illness prevents the child from participating comfortably in facility activities.

B) The illness results in greater care needs than the childcare staff can provide without compromising the health and safety of the other children.

C) The child has any of the following conditions:
- ***Temperature:*** Temperature is 101 degrees or greater accompanied by behavioral changes (irritability, sore throat, rash, lethargy).
- ***Symptoms and signs of possible severe illness:*** Unusual lethargy, uncontrollable coughing, irritability, persistent crying related to ill feeling, difficulty breathing, wheezing, or other unusual signs.
- ***Uncontrolled Diarrhea****:* Watery stool that cannot be contained in the diaper (leaking), or cause frequent "accidents" in toilet-trained children. Child may return to school when loose stool can be contained in a diaper or when child is no longer having "accidents" and frequency is no more than 2 stools above normal during the program day.
- ***Vomiting illness****:* Vomiting more than two times in the previous 24 hours, unless the vomiting is determined to be caused by a non-infectious condition.
- ***Mouth sore with drooling that the child cannot control****:* Unless the primary physician or public health authority states that the child is noninfectious.
- ***Rash with fever or behavioral changes****:* Until primary care provider determines that the illness is not infectious
- ***Pink Eye (bacterial conjunctivitis****):* Indicated by pink or red conjunctiva with white or yellow eye mucous drainage and matted eyelids after sleep. NOT EXCLUDED UNLESS CHILD ALSO HAS EYE PAIN, FEVER, OR REDNESS AND SWELLING AROUND THE EYELIDS. For children with these symptoms, please consult primary care provider.
- ***Abdominal pain****:* For pain that continues for more than two hours or intermittent pain associated with fever or other symptom of illness
- ***Tuberculosis***: Excluded until health provider or health official states that the child may return to class.
- ***Scabies, Head Lice, or other infestations****:* Upon identification of lice, or other infestation, parent/guardian will be notified, in a confidential manner, at the end of the school day. The child may return to school after the first treatment has begun. Please contact preschool nurse at (951) 222-7850 for intervention assistance.

- ***Impetigo**:* Cover lesions. Child may return to school after first treatment. Treatment may be delayed until the end of the program day.
- ***Strep Throat or other streptococcal**:* Child may return to school 24 hours after beginning antibiotic treatment.
- ***Chicken Pox**:* Child may return when all lesions have dried or crusted (usually 6 days after onset or rash) and no new lesions have appeared for at least 24 hours.
- ***Pertussis**:* Excluded until after 5 days of appropriate antibiotic treatment.
- ***Mumps**:* Excluded until 5 days after onset of parotid gland swelling.
- ***Hepatitis A virus**:* Excluded until one week after onset of illness or jaundice if the child's symptoms are mild, or as directed by the health department.
- ***Measles**:* Excluded until 4 days after onset of rash.
- ***Rubella**:* Excluded until 7 days after onset of rash.

A child whose illness requires that the child be sent home from the facility shall be given appropriate attention to his/her needs, so long as the attention does not compromise the care of other children in the facility, until the ill child's parent/guardian/emergency contact person arrives to remove the child.

A child with uncontrolled vomiting or diarrhea shall be provided separate care apart from the other children, with extra attention given to hygiene and sanitation, until the child's parent/guardian/emergency contact person arrives to remove the child.

During the course of any identified outbreak of any communicable illness at the facility, a child shall be excluded if the local health official or health care provider determines that the child is contributing the transmission of the illness at the facility.

REFERENCES:

***Caring for Our Children,* 3rd edition (*CFOC3* electronic version)** with the publication *of* *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*, 4th edition (*MID4*) and *Red Book: 2015 Report to the Committee of Infectious Diseases.* 30th Edition (Red Book)

I have received, understand, and will comply with the Child Illness and Exclusion Policy

Signature of Parent/Legal Guardian _____ Date _____

Child's Name _____

Local ID: **JURUPA UNIFIED SCHOOL DISTRICT** Grade:

State ID: ***Annual Emergency Information Form*** School:

PARENT/GUARDIAN NOTE: Please review the information on this form, update changes, sign and return to school

Name of Student (Last, First Middle) | Gender | Advisor | Birthdate | Home Language

Student's Home Address | City | Zip Code | Home Phone | Phone Unlisted?

Mailing Address (If different) | City | Zip Code

In the event of illness or an emergency at school, my child may be released to the following adults:

Parent 1

Name:		Lives with Student?
Type: Parent or Legal Guardian	Relationship:	Email:
Home Phone:	Work Phone:	Cell Phone(txt Y/N):
Address:		
Employer and City:		

Parent 2

Name:		Lives with Student?
Type: Parent or legal Guardian	Relationship:	Email:
Home Phone:	Work Phone:	Cell Phone(txt Y/N):
Address:		
Employer and City:		

Emergency Contact

Additional Person(s)	Relationship	Home Phone	Work Phone	Cell Phone (txt Y/N)

Student's Health Information

My child has special health needs as follows:

Medical Conditions | Medications | Allergies

Name of Student's Doctor | Doctor's Address | Doctor's Phone Number

I, the undersigned parent/guardian of the student (shown on this form) , a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care to be rendered under the general or special supervision and upon the advice of a physician, surgeon or dentist under provisions of the Medicine Practice Act, or Dentist practice Act. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care but is given to provide authority and power for the physician/dentist to render care which in his/her best judgment may be deemed advisable. This authorization is given pursuant to the provisions of Sections 6900 through 6910 of the Family Code of California. Signature certifies that the foregoing information is correct and acknowledges the responsibility of the parent/guardian to immediately notify the school in writing of any changes in the information on this form.

I understand that Jurupa Unified School District DOES NOT provide accident medical insurance for my child for school related injuries but does offer student accident insurance for voluntary purchase. I certify that I have received an application for Student Accident Insurance as offered.

☐ **I AM taking student accident insurance as offered.** ☐ **I am NOT taking student accident insurance as offered.**

Special Information or instructions (Physical problems, Medical case number (Kaiser), Parental Restrictions, etc):

Parent/Guardian Certification and Authorization:

Name of person completing this form (Please print) | Relationship to Student

Signature of parent/guardian cerifying information is accurate | Date

Grade: First Name: Last Name:

Jurupa Unified School District

HOME LANGUAGE SURVEY

Name of Student: _____ _____ _____
Last First Middle Grade Birthdate

_____ _____
Student ID# (the school will provide this number) Date

_____ _____
District and school last attended Current Assigned School

_____ _____
Country of Origin Current Assigned Teacher

_____ _____
Date of U.S. entry (if applicable) Date of entry into CA (if applicable)

The California Education Code requires schools to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students.

Your cooperation in helping us meet this important requirement is requested. Please answer the following questions and have your son/daughter return this form to his/her teacher. Thank you for your help.

1. Which language did your son/daughter learn when he/she first began to talk? _____
2. What language does your son/daughter most frequently use at home? _____
3. What language do you use most frequently to speak to your son/daughter? _____
4. Name the languages in the order most often spoken **by the adults** at home. _____

_____ _____
Name of the Parent/Guardian Phone number

This form must be filled out *completely*.

Jurupa Unified School District
Head Start/State Preschool/Title I

Date/Fecha: _____

☐ I am opting in for the Preschool Program to contact me via text and/or email. *Me apunto para que el programa de Head Start se contacte conmigo por mensaje de texto o correo electrónico.*

Cell Phone Number: _____
Número de teléfono celular

Alternative Number: _____
Número secundario

Email: _____

☐ I am opting out for the Preschool Program to contact me via text and/or email. *Opto no apuntarme para que el programa de preescolar se contacte conmigo por mensaje de texto o correo electrónico.*

Child's Name/ Nombre del niño/a: _____

Parent's Name/Nombre del padre/tutor: _____

Parent's Signature/Firma del padre/tutor: _____

Jurupa Unified School District
Education Services
Head Start/State Preschool/Title I
Parent Interest and Volunteer Survey
Encuesta de Interés de Padres y Voluntarios

_____ _____ 1☐ 2☐ AM☐ PM☐ FD☐
Child's Name/Nombre del niño Site/Escuela:

Parent Name/Nombre del padre: _____ Date/Fecha: _____

Please let us know what training topics and volunteer opportunities you are interested in/Por favor déjenos saber cuáles temas de capacitación y oportunidades de voluntariado le interesan:

Classroom Volunteer / Voluntario en el salón:

I can help in the classroom with/Yo puedo ayudar en el salón:

- ☐ Storytelling/A contar cuentos
- ☐ Art projects/Con proyectos de arte
- ☐ Special projects/ Con proyectos especiales
- ☐ Helping at mealtimes/A la hora de los alimentos
- ☐ Translation/Con traducciones
- ☐ Small group activities/Con actividades con grupos pequeños
- ☐ Sharing family tradition/Culture/Language/ Compartir tradiciones familiares/cultura/idioma
- ☐ Reading to children/Leerle a los niños/as
- ☐ Music (singing, dancing, musical instruments) Música (cantar, bailar, instrumentos musicales)
- ☐ Preparing materials/Preparando materiales
- ☐ Lending library/En la biblioteca de prestamos
- ☐ Food experience/Con proyectos de cocina
- ☐ Playground helper/En el patio de recreo
- ☐ Other skills/talents/Otros talentos/destrezas_____

Home Volunteer / Voluntario en casa:

I can help at home with school activities by / Yo puedo ayudar en casa con las actividades en la clase al:

- ☐ Preparing materials (sorting, cutting, and/or drawing items for classroom activities) Preparar materiales (separar, recortar y/o dibujar objetos para actividades en el salón)
- ☐ Collecting items for art projects (i.e., cereal boxes, egg cartons) Reunir objetos para proyectos de arte (cajas de cereal, cartones delos huevos)
- ☐ Special project preparation/Preparar proyectos especiales
- ☐ Other skills/talents/Otros talentos: _____

Parent Committee/Representante del Comité de Padres o del Consejo de Políticas:

I am interested in the following leadership role on the Parent Committee:
Yo estoy interesado/a en las siguientes funciones de liderazgo en el Consejo de Políticas:

- ☐ Chairperson/President
- ☐ Vice Chairperson/Vicepresidente
- ☐ Treasurer/Tesorero
- ☐ Secretary/Secretario/a
- ☐ Parent Advisory Committee Site Representative/Representante del plantel ante el Consejo de Padres
- ☐ Parent Advisory Committee Site Alternate Representative/Suplente del representante del Consejo de Padres

I am available on the following mornings/Estoy disponible los siguientes días, por la mañana:
☐ Monday/Lunes ☐ Tuesday/Martes ☐ Wednesday/Miércoles ☐ Thursday/Jueves ☐ Friday/Viernes

Training Topics/Temas:

I am interested in obtaining more information/training on the following
Estoy interesado/a en obtener más información o entrenamiento en los siguientes:

- ☐ Literacy/Alfabetización
- ☐ School Readiness/Preparación para la escuela
- ☐ Child Abuse Prevention/Prevención del abuso infantil
- ☐ Financial / Finanzas
- ☐ Child Growth & Development/Crecimiento y desarrollo infantil
- ☐ Volunteer Training/Capacitación para ser voluntario/a
- ☐ First Aid/Promeros auxilios
- ☐ Disaster Preparedness/Preparación para casos de desastre
- ☐ Positive Discipline/Disciplina positiva
- ☐ Health & Nutrition/Salud y nutrición
- ☐ Emotional Wellness/Bienestar emocional
- ☐ Other Topics/Otros temas: _____ _____ _____ _____

Jurupa Unified School District

Health & Developmental History

Child's Name: _____ DOB: _____

Health History (conditions listed may require a Care Plan)	**Yes**	**No**	**If yes, please explain**
1. Does your child have any allergies? a. When eating any foods? ..... b. When near animals, furs, insects, dust, etc.?..... c. When taking any medications?.....	____ ____ ____	____ ____ ____	Describe allergy: _____ Child's reaction: _____ Is medication required? Yes No *(circle one)* Medication name? _____
2. Within the past year, has your child ever had a convulsion or seizure?			If yes, when did it last happen? _____ What medication was given? _____
3. Is your child being treated by a physician for any condition (asthma, diabetes, heart condition, etc.)?			If yes, for what condition? _____ Physician Name: _____
4. Is your child taking any prescribed medications now? a. Will any medication need to be given by staff? *(If yes, care plan required)*	____ ____		If yes, what medication is taken?
Developmental Milestones	**No**	**Yes**	**If NO, please explain or describe**
5. Did your child start walking independently between 9 months and 14 months of age? ( ) Not applicable, child is less than 9 months of age.			
6. Did your child say his or her first words between 12 months and 26 months of age? ( ) Not applicable, child is less than 12 months of age.			
7. Does your child show interest in playing with other children? ( ) Not applicable, child is less than 18 months of age.			
8. With supervision, can your child successfully use the restroom? ( ) Not applicable, child is less than 36 months of age.			
9. With minimal adult assistance, can your child dress him or herself? ( ) Not applicable, child is less than 36 months of age.			
10. Do you think your child is developing at approximately the same rate as other children his or her age?			
Social & Emotional Characteristics	**Yes**	**No**	**If yes, please explain or describe**
11. Do you consider your child to be shy or timid?			
12. Has your child ever hurt a pet on purpose?			
13. Does your child have any fears?			
14. Is your child overly sensitive (cry easily, or gets upset easily)?			
15. Does your child hit, kick, or throw things when upset?			
16. Is there anything else you would like to tell us about your child?			

Parent Signature: _____ Date: _____

FOR OFFICE USE ONLY

Comments: _____

_____

_____

_____

_____

JURUPA UNIFIED SCHOOL DISTRICT
Head Start/State Preschool/Title I

Food History

Child's Name: _____ DOB: _____ ☐ M ☐ F

Parent/Guardian Name: _____ Phone: _____

Nutrition is a very important part of our program. In order for us to meet your child's nutritional needs, please answer the following questions regarding your child's eating pattern. You might need additional documentation such as medical statement and/or care plan from your doctor prior to your child's first day of school. These forms can be obtained by site staff.

1. Is your child allergic or intolerant of any food or milk? ☐ Yes ☐ No *If yes, medical statement required.*
   What foods should be eliminated?
   _____

2. Is your child now on a special diet? ☐ Yes ☐ No *If yes, medical statement is required.*
   What foods should be eliminated?
   _____

3. Are medications required at school? ☐ Yes ☐ No *If yes, care plan is required.*

4. Does your child have trouble chewing or swallowing? ☐ Yes ☐ No
   If yes, explain: _____
   _____

5. Is your child currently on the Women, Infant, and Children (WIC) Program? ☐ Yes ☐ No

6. Is your family currently receiving Supplemental Nutrition Assistance Program (SNAP)? ☐ Yes ☐ No

7. At what times does your child eat the following meals and snacks?

Meal	How many days per week	Time	Meal	How many days per week	Time
Breakfast	1, 2, 3, 4, 5, 6, 7		A.M. Snack	1, 2, 3, 4, 5, 6, 7	
Lunch	1, 2, 3, 4, 5, 6, 7		P.M. Snack	1, 2, 3, 4, 5, 6, 7	
Dinner	1, 2, 3, 4, 5, 6, 7		Bedtime Snack	1, 2, 3, 4, 5, 6, 7	

8. What foods does your child like? _____

9. What foods does your child dislike?
   _____

10. How much water does your child drink each day? *Circle:* 1 cup 2 cups 3 cups 4 cups 5 cups 6 cups 7 cups 8 cups

11. Does your child take vitamin or mineral supplements? ☐ Yes ☐ No *If yes, what kind?* _____

12. Does your child now eat dirt, clay or other non-food items? ☐ Yes ☐ No *If yes, explain:* _____

13. Does your child take a bottle? ☐ Yes ☐ No

14. Do you have any additional concerns about your child's growth, nutrition, or eating? ☐ Yes ☐ No
    If yes, explain: _____
    _____

Jurupa Unified School District
Head Start/State Preschool/Title I

Screenings/Treatments Consent

Child's Name: _____ Date of Birth: _____

Welcome to the Jurupa Unified School District Preschool Program:

To ensure all enrolled children are healthy and ready to learn, we are required to conduct the following health and developmental screenings within the first 45 days. The results of each screening will be shared with parents/guardians and if follow-up is needed, parents/guardians are responsible for ensuring that treatment is completed. Parents/Guardians will be provided with the necessary form for each screening, which is **required** to be completed by the provider, upon the completion of treatment.

Screenings/Treatments

- Dental screening (Teeth)
- Auditory screening (Hearing)
- Vision screening (Eyes)
- Height/Weight and Measurements (Growth)
- Developmental screening (Learning)

_____ _____

Signature of Parent/Legal Guardian Date

Declined Screenings Statement

Please do not screen my child for the following: _____

I understand that if I choose to decline a screening, *I must provide documentation that it has been done*.

_____ _____

Signature of Parent/Legal Guardian Date

Screening documentation received? Yes No

Fluoride Consent

Under a dentist's supervision, participants will receive a fluoride varnish treatment that will provide a protective coating to prevent tooth decay.

☐ I want my child to receive a one-time fluoride varnish application.

☐ I do not want my child receive fluoride varnish application.

_____ _____

Signature of Parent/Legal Guardian Date

(Revised 4/4/18 CH)

Jurupa Unified School District
Head Start/State Preschool/Title I

Physical Exam Agreement

Child's Name: _____

All children enrolled and participating in the JUSD Preschool Programs are required to obtain a complete physical examination, either completed within one year prior to entry into the program, or within 30 days of entry. Anemia screening results and lead level results are due within 45 days of entry. Immunizations must be up to date prior to entry into the program. If you do not have a physician, we can provide a resource list of local providers.

☐ **My child had a physical within the last year.** *I understand I must provide a copy.*

Date of last physical exam: _____ Doctor's name: _____

☐ **My child has not had a physical in the past year. I will schedule an appointment.**

I understand that my child is required by program regulations to provide **lead test results and hemoglobin/hematocrit (blood) level results within 45 days** of enrollment and a **current physical examination within 30 days** after the date my child is enrolled. If not provided, I understand my child's enrollment in the program may be terminated.

I understand that physical and anemia results are good for 1 year. A new physical and anemia results must be submitted prior to or upon expiration.

*If the physician has ordered medication, the specified medication MUST be provided and care plan be completed and returned to the School Readiness Center prior to entry into the classroom.

*If the physician confirms a child requires special meal accommodations due to allergies and/or intolerances, a **Medical Statement to Request Special Meals and/or Accommodations** must be completed and returned to the School Readiness Center prior to entry in the classroom.

_____ _____
Signature – Parent/Legal Guardian Date

(Rev. 3/23/18 CH)

Jurupa Unified School District

Head Start/State Preschool (CSPP)/Title I

AUTHORIZATION FOR EXCHANGE OF HEALTH & EDUCATION INFORMATION

Student/Patient Name: _____ Date of Birth: _____

Address: _____

_____ Phone Number: _____

I hereby authorize my child's Healthcare Providers and School Healthcare Professionals to exchange health and education Information/records for the purpose listed in the box below.

Child's Healthcare Providers

Doctor's Office
Dental Office
Mental Health
Nutritionist

JUSD School/ Healthcare Providers

Program Nurse
Disabilities Consultant
Mental Health Consultant
Nutritionist
Dentist
JUSD Special Education Department

Description: Records Information to be Released

School professionals may share protected health and education information with appropriate members of the educational team for use in meeting the student's health and educational needs. This will be done on a "need to know" basis, in a confidential manner, and may also include communication between healthcare providers and school healthcare professionals to facilitate this process.

Purpose: This information will be used for the following purpose (s):

1. Educational evaluation and program planning and monitoring
2. Obtaining required health care documents (physicals, lab results, immunizations)
3. Health assessment and planning for health care services and treatment in school
4. Medical evaluation and treatment

Authorization

I hereby consent to the exchange or release of my child's health and education information for the purposes described above. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care or education.

_____	_____	_____
Signature of Person Giving Consent	Relationship to Student	Date