



Enrollment Information

Preschool registration is located at:

Capital City Child Development Center
7220 24th Street
Sacramento, CA 95822
(916) 433-2736

or

Hiram Johnson Family Education Center
3535 65th Street
Sacramento, CA 95820
(916) 277-7151

Hours of Operation:

Monday to Thursday 8:00 AM – 4:00 PM (please arrive by 3:15 PM)

Friday 8:00 AM – 12:00 PM (please arrive by 11:15 AM)

Closed the first Friday of every month

Step 1: A program request form will be filled out and completed. You will be placed on a waitlist for your first school of choice.

Step 2: When a space becomes available at your school of choice, you will be contacted by one of our enrollment staff. You will have 48 hours to return your complete packet to the office

When enrolling please bring the following documentation:

For Child:

- ∞ Birth Certificate
- ∞ TB clearance (within 12 months)
- ∞ Physical Exam (within 12 months) or Appointment
- ∞ Dental Exam (within 12 months) or Appointment
- ∞ Immunization Record
- ∞ Proof of W.I.C.

For Parent:

- ∞ All sources of Income verification (last 30 days) for all adults (parent/guardians) If applicable: TANF, Food Stamps
- ∞ Address verification (i.e. utility bill/rental agreement)*
- ∞ Parent TB clearance (within 12 months) or Waiver
- ∞ Birth Certificate for all siblings under 18-years-old living in the home
- ∞ Verification of “one-parent status” (i.e. SMUD, PG &E, Water, Child Support document, Divorce document, Tax document,)

In addition:

- ∞ Proof of Employment or School/Training (Full-day preschool only)
- ∞ Individualized Education Plan (IEP) if you child is receiving Special Education services
- ∞ Guardianship/Custody documents (if applicable).

* If residing with another person (relative, etc.), please complete the Declaration of Residence form of the person

Parents/guardians must have the minimum required documents, along with the enrollment packet, to complete the application for preschool registration.

Please note: Unfortunately, we can no longer accept incomplete applications.



Sacramento City Unified School District
Child Development Department
Program Request Form

Age Priority _____
 Criteria/Ranking # _____

Please **fax** this form to one of the following registration centers:
 Capital City CD Center, **433-2738** or Hiram Johnson Family Ed. Center, **277-6698**
 For registration information, please call: Capital City CDC – **433-2736**; Hiram Johnson FEC – **277-7151**

Date Requested: _____

New Student

How did you hear about us? _____

Transfer from: _____

Program Requested

Early Head Start

Site Preference

- Home Based
- Center Based

- Capital City
- American Legion
- Elder Creek
- Hiram Johnson

Head Start/State Preschool

- Part Day AM PM
- Wrap
- Full Day-Child Care
- Home Based

Site Preference

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Enrollment Criteria (Mandatory Information)

Family Information

1. Parent (or Student Parents') Name: _____ Date of Birth: _____

2. Parent (or Student Parents') Name: _____ Date of Birth: _____

Child's Name: _____ IEP/IFSP? Yes No Date of Birth: _____

Address: _____ Phone #: _____ Primary Language: _____

City: _____ CA Zip Code: _____ In District? Yes No

Child's Name: _____ Date of Birth _____

Child's Name: _____ Date of Birth _____

Child's Name: _____ Date of Birth _____

Family Size: _____ **Gross Income** (pay stubs, TANF, SSI, child support, etc.): _____

Are you: working or seeking employment in school parent incapacitated

Early Head Start Only

If pregnant, due date: _____ Adult Parent/Guardian Name: _____ Contact #: _____

Please list any special circumstances or history (i.e. educational needs, disabilities, family situations, emergency needs, health, IEP/IFSP, etc.) Please list any current services your family is receiving or ties to programs or agencies.

Receiving office use only:

Request received on: _____ Given to CDS/Home Visitor on: _____ Name: _____

Follow-up:

- Head Start Qualified
- State Qualified
- Over Income
- 100 – 130%
- Foster Child
- Homeless
- CPS
- Special Needs

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT - CHILD DEVELOPMENT DEPARTMENT
Fax: Capital City: (916)433-2738 or Hiram Johnson: (916)277-6698
PRESCHOOL PHYSICAL EXAMINATION

CHILD NAME: _____ BIRTH DATE: _____ PRESCHOOL: _____

Parent's/Guardian's Authorization: I hereby give my consent to Child Development Department representative and my physician to exchange health information concerning my child.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

REQUIRED (Note: Incomplete or blanks in this section will be returned to Physician to complete)

Date: _____ Hemoglobin/Hematocrit: _____ Receiving Treatment/Iron? Yes No
 Date: _____ Blood Lead: _____ ug/dl
 Date: _____ TB Risk Assessment Given by Provider: Yes No → Child has TB Risk? Yes No
 If Yes, PPD Date Given: _____ Date Read: _____ Results: _____

REQUIRED (Starting at Age 3)

Date: _____ Blood Pressure: _____
 Date: _____ Vision: _____ R: 20/____ Pass Fail L: 20/____ Pass Fail
 Date: _____ Hearing: (25db @1000,2000,&4000) R: Pass Fail L: Pass Fail

Date of Physical Exam:	HEIGHT:	IN	WEIGHT:	LBS
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EXAMINATION RESULTS	NORMAL	ABNORMAL	DESCRIBE FINDINGS/COMMENTS
GENERAL APPEARANCE			
HEAD, EARS, EYES, NOSE & THROAT			
TEETH / GUMS			
HEART / LUNG			
ABDOMEN / GENITOURINARY			
EXTREMITIES / SKELETAL			
POSTURE AND GAIT			
NEUROLOGICAL (Fine, Gross Motor)			
SPEECH			
SKIN			
DEVELOPMENTAL STATUS			

Health Concerns/Diagnoses:

Food Allergy: No Yes, List: _____

Lactose Intolerance: No Yes Other: _____

Medications Taken at Home? No Yes, List: _____

Medications Required at School? No Yes, List: _____

Physical Activity: No Restrictions Limited, Explain: _____

Special Education Service:

Speech Impairment Developmental Delay Learning Disability Orthopedic Disability
 Emotionally Disturbed

Active IEP? No Yes

Dental Referral: No Yes; Dental Varnish Given: No Yes; NaFI Given: No Yes

Nutrition Counseling Given: No Yes Nutrition Counseling Referral: No Yes

PHYSICIAN NAME (PRINT) _____ PHYSICIAN'S SIGNATURE _____

MEDICAL GROUP NAME _____ PHONE: (____) _____ FAX: (____) _____

Street Address _____ City: _____ State: _____ Zip: _____

Student's Last Name (Legal) _____ First Name _____ Middle _____	<u>School Year</u> _____ School _____	<p style="text-align: center;"><i>Office Use Only</i></p> Teacher/Cnslr. _____ Grade _____ Room _____ Bus _____ CONCAP [] Hm. Sch. _____ Sp. Ed. [] RSP [] Eth. Cd []
Street Address _____ Apt # _____ Zip Code _____ Home Phone (1) _____ Home Phone (2) _____ LANGUAGE SPOKEN AT HOME: _____	<u>Date of Birth</u> _____ Last School of Attendance _____ City _____	
Parent/Guardian 1 Name _____ Address _____ Relationship _____ Driver's Lic. # _____	Name & Address of Employment _____ _____ E-mail address _____	Work Phone: _____ Cell Phone: _____ Pager: _____
Parent/Guardian 2 Name _____ Address _____ Relationship _____ Driver's Lic. # _____	Name & Address of Employment _____ _____ E-mail address _____	Work Phone: _____ Cell Phone: _____ Pager: _____
Day Care Provider: _____ Phone #1: _____ Phone #2: _____		
List names of other children attending this school: _____	School is authorized to share my phone number with the PTA: Yes _____ No _____	Check here if student will be riding the bus: Yes _____ Bus Number: _____
Parent/Guardian with whom the child lives _____ Phone _____ If the parents are divorced or separated, to whom has physical custody been given? (attach verification) _____		

Please Read:

The parent/guardian is responsible for keeping the school informed of updates or changes to the student's emergency information. The school shall be notified, in writing, of telephone or address changes within three days (3) of the occurrence. If the school is unable to reach anyone on this card in an emergency or if a student is left unattended during non-school hours, the school will contact law enforcement or Child Protective Services.

I have read this and understand my responsibility. _____ Parent / Guardian Signature

Note: The adults listed below are authorized to pick up and care for the above-named student. The student may be released to others with written or verbal authorization.

Name 1: _____ Phone: _____ Relationship _____	Name 2: _____ Phone: _____ Relationship _____
Name 3: _____ Phone: _____ Relationship _____	Name 4: _____ Phone: _____ Relationship _____
Name 5: _____ Phone: _____ Relationship _____	Name 6: _____ Phone: _____ Relationship _____
Name 7: _____ Phone: _____ Relationship _____	Name 8: _____ Phone: _____ Relationship _____

Special instructions / comments / (Include instructions for pickup of student):

General Health Information

CHECK HERE IF THERE ARE NO HEALTH PROBLEMS.

Does student wear glasses or contact lenses? Yes No

Does student wear hearing aids or is the student diagnosed with hearing loss? Yes No

PLEASE CHECK ALL THAT APPLIES TO YOUR CHILD:

- | | | | |
|----------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Frequent nosebleeds |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Seasonal Allergy | <input type="checkbox"/> Severe Allergy |
| | | | <input type="checkbox"/> Epi-pen |

Other: _____

LIST ALL MEDICATION, WITH DOSE, TAKEN BY YOUR CHILD

AT HOME _____

AT SCHOOL _____

Does student have condition that limits participation in: classroom physical education

Explain: _____

(NOTE: The physician must provide a note explaining the limitation and reason for the student's limited participation in physical education and the note must be updated every school year)

SPECIAL INSTRUCTIONS/COMMENTS: List any special health needs or medical problems, including specific allergic reactions (food, bee sting, etc.), if student has an active emergency care plan, medical 504 Plan, Diabetic Medical Management Plan, etc.

Please Read:

- * California Education Code 49408 states that school districts may require that emergency information be kept current.
- ** The parent or legal guardian of a public school pupil on a continuing medication regimen shall inform the school nurse or other designated certificated employee of the medication being taken.
- *** California Education Code 49423 requires that if medications are to be taken at school, there must be a medication form on file at school, signed by both parent and physician.

EMERGENCY AUTHORIZATION

In the event of an emergency, when a parent/guardian is unavailable, I authorize school personnel to make such arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgment. I further authorize the physician named below to undertake such care of my child, as he/she considers necessary. In the event said physician is not available, I authorize such care and treatment to be performed by a licensed physician or surgeon. I understand that the parent or guardian is responsible for the cost of such emergency care.

Physician Name _____ Phone _____ Pager _____

Emergency Facility/Phone _____

Does this student have Health Insurance? Yes or No Does this student have Dental Insurance? Yes or No

Name of Insurance Coverage or Health Plan Provider: _____ Student's Medical Record Number _____

If not, I give permission to SCUSD to share this information to help apply for health insurance for my child. Yes No

I certify that the information is true and correct.

Parent/Guardian Signature _____ Date _____



Sacramento City Unified School District
CHILD DEVELOPMENT DEPARTMENT

PARENT/GUARDIAN NOTIFICATION AND CONSENT FORM

All information is kept confidential

Child's Name: _____

Child's Date of Birth: _____

We operate under federal, state, district and program guidelines to provide safe and developmentally appropriate experiences for your child. This form provides information regarding our program requirements and also program services that are designed to identify any health and learning problems that may interfere with your child's learning experiences now and in future years. We encourage you to be actively involved in your child's health care and school-related activities.

NOTIFICATIONS:

Our programs require all enrolled children to have up-to-date immunizations (including a current TB skin test). In addition, all enrolled children must have a complete physical examination within 30 days of enrollment and an annual dental examination.

I understand that failure to provide this information within the required timelines may result in my child's termination from the program.

Our programs are licensed by the Department of Social Services and comply with the following regulation: Inspection Authority/Dept. of Social Services – Title 22, Division 12, Chapter 1, Article 4, Section 101200(b)(1)(c)(1)(d)

I understand that the Department of Social Services has the authority to: (b) interview children or staff without prior consent, (c) inspect, audit, and copy child or child care center records upon demand during normal business hours (d) observe the physical condition of the children, including conditions that could indicate abuse, neglect or inappropriate placement.

Our programs enroll out-of-district children, with priority enrollment provided to SCUSD residents. When an out-of-district child becomes kindergarten eligible, he/she must register at his/her district's school of attendance.

I understand that I must enroll my child in his/her district's school of attendance when he/she becomes eligible for kindergarten (5 on or before September 1).

CONSENTS:

- 1. Screening: I consent to have my child screened in the following areas: Hearing/Vision, Height/Weight, Social/Emotional, Speech/Language, General Development.
2. Observation: I consent to have my child observed by the Child Development Department's support staff with the understanding that I will be informed prior to these observations and provided the opportunity to provide my written authorization for these services.
3. Assessment: I consent to have my child participate in preschool assessments.
4. Field Trips: I consent to have my child participate in field trips with the understanding that I will be notified in advance of each trip.
5. Photographs: I consent to have my child photographed for the purposes of display in the classroom, posters, or for use in publications dealing with early childhood education.
6. Forwarding Records: I consent to have my child's records forwarded to the next school of attendance, or when another district requests the records (exception: special education records).

Parent/Guardian

Print: _____ Sign: _____ Date: _____

Distribution: Original – Child's File Copy – Parent/Guardian



Sacramento City Unified School District
CHILD DEVELOPMENT DEPARTMENT

Preparing Your Child for Comprehensive Screenings



Child Development administers various screenings to children throughout the course of the school year. Possible screenings include speech, hearing, vision, dental, blood pressure and BMI, which are completed by a designated nurse. Behavioral, academic and social screenings are completed by the child's assigned teacher or resource staff.

Additionally, your child's teacher will share information with you about the screenings. Information regarding screenings is included in the enrollment packet and you will also receive results after screenings are completed.

In an effort to decrease your child's anxiety about screenings and to ensure best results, please talk to and prepare your child for screenings.

Ideas on how to prepare your child for screenings:

- Tell your child in advance who will complete the screening and describe the type of screening. Describe the *fun* in sharing what they know!
- Go to the library and read books on screening topics and discuss.
- Role play the types of screenings. For example, for a vision screening, have the child cover one eye and ask, "What do you see?" etc. If it is a developmental screening, ask them to point out colors, count to ten, their name and age, etc.
- Talk about the screening activity and discuss your child's feelings about it.

If you have any questions, please contact your child's teacher.



FUN WAYS TO PREPARE FOR YOUR CHILD'S SCREENINGS

Make the following activities a fun game. Mistakes are okay, as they are learning the experience of screenings. Keep the games short and sweet (5-10 minutes or less).

For Height

Measure your child's height on a wall with a measuring tape, yard stick, or use stackable items (e.g., you are five straws tall!).

For Weight

Weigh your child on a scale. Weigh an apple or can of beans first to make it fun and compare them.

For Hearing

Have your child wear earphones and listen to a story or a song and have them drop a cracker into a bowl every time they hear a repeating sound (e.g., Every time you hear the bell, drop a cracker into the bowl). If you don't have earphones, just practice dropping an item into a bowl when they hear a directed sound (e.g., Every time you hear me whistle, or every time you hear me shake the cereal box, drop a cotton ball into the bowl).

Go on a nature walk and have your child listen for specific sounds (e.g., Every time you hear a bird chirp, raise your hand).

For Vision

Have your child tell you what they see 10 feet away when first covering their right eye, and then covering their left eye.

Play Simon Says while your child covers the right eye, and then again the left eye (e.g., Simon Says tell me what you see on the refrigerator? Simon Says tell me what you see on the kitchen counter?).

For Blood Pressure

Talk about the special "hug" on the arm they will be experiencing (a warm and caring way to get their blood pressure).

Have your child **see you** get your blood pressure taken (Local CVS, Walgreens, and Rite Aid have for **ADULTS**- not for children's use)

For Developmental (Academic)

Tell your child you're going to play a "Question" game. You ask them questions like, "What's your first name? What's your last name? What's your middle name? How old are you?"

Look at pictures and discuss what the same is and what's different. Count items in the picture. Draw lines/shapes on paper that you've asked them to draw.

Follow directions games (e.g., Go touch the door, then clap your hands). Make the directions increasingly more difficult and increase the amount of steps (e.g., Close the book, jump up, and give me a high five).

Sacramento City Unified School District
CHILD DEVELOPMENT DEPARTMENT
PRESCHOOL HEALTH AND DEVELOPMENT HISTORY Yr1 Yr 2 Yr 3

Child's Name: _____ Birthdate: _____ M F
Preschool Site: _____ AM PM Full Day (CC or Wrap)
Medical Insurance: Medi-Cal California Covered None Private Insurance: _____
Name of Child's Doctor: _____ Phone: (____) _____ Medical Plan: _____
Name of Child's Dentist: _____ Phone: (____) _____ Dental Plan: _____

HEALTH HISTORY

Does your child have any of the following:

- Yes No Asthma
- Yes No Diabetes
- Yes No Heart problem If Yes, describe: _____
- Yes No Seizures If Yes, describe type: _____
- Yes No Cerebral Palsy
- Yes No Severe bee sting/insect bite allergy
- Yes No Myringotomy (vent) tubes in ears
- Yes No Hearing Aids
- Yes No Vision Problems (child squints, eyes crossed, "lazy eye", etc.)
- Yes No Eyeglasses prescribed by doctor If Yes, does child wear eyeglasses? Yes No
- Yes No Does your child use mobility equipment? (leg/ankle braces, walker, wheelchair) : _____
- Yes No Sickle Cell Disease / Sickle Cell Trait (circle one)
- Yes No Eczema Other type skin problem, describe: _____
- Yes No Anemia (low iron in blood)
- Yes No Airborne allergies If Yes, to what? _____
- Yes No Is your child exposed to tobacco smoke?
- Yes No Any major illness or surgery? Please describe: _____
- Yes No Other medical needs or concerns? Please describe: _____
- Yes No **Is your child seeing one of the following specialists:**
 - Audiologist ENT (ear, nose, throat doctor) Neurologist
 - Optometrist (eye doctor) Speech Therapist Other: _____
- Yes No **Has your child ever received services from:**
 - Alta Regional Center California Children Services (CCS) Mind Institute (UCD)
 - Shriner's Hospital Special Education Services Other: _____

MEDICATION

- Yes No **Does your child take any medication?**
If Yes, list: _____
- Yes No **Will your child need to take any medication at school?**
If Yes, list: _____

DENTAL HISTORY

- Yes No Has your child been seen by a dentist within the last 12 months?
 - Date last seen by dentist: _____
 - Next dental appointment is on: _____
- Yes No Does your child have any cavities?
- Yes No Does your child have any problems with painful teeth or gums?
- Yes No Does your child drink from a bottle?

NUTRITION HISTORY

- Yes No **Is your child *allergic* to any foods?** *(Please notify our preschool nurse)*
If Yes, list: _____
- Yes No **Has your child ever been prescribed an EpiPen or Antihistamine for this food allergy?** *(Please notify our preschool nurse)*
- Yes No **Is your child lactose intolerant?**
- Yes No **Is your child on a special diet or tube feedings?** **If Yes, describe:** _____
- Yes No **Is there any food your child should not eat for *religious preference* reasons?**
If Yes, list: _____
- Yes No **Is your child vegetarian / vegan?**
- Yes No **Does your child eat any non-food items (such as clay, dirt, chalk) on a regular basis?**
If Yes, describe: _____
- Is child's doctor aware of this condition? Yes No
- Yes No **Does your child receive WIC?** WIC Number: _____

How many times a day does your child have the following foods (includes school meals):

	1 - 2	3 - 5	> 6
Cake, cookies, candy, chips			
Soda, sweetened drinks			
Dairy: Milk, cheese, yogurt			
Non-meat: Beans, lentils, peanut butter			
Fruit: Apples, oranges, bananas			
Vegetables: Broccoli, carrots, green beans			
Grains: Cereal, bread, rice, grits, tortilla			

DEVELOPMENT HISTORY: (complete for Year 1 only)

- Yes No Walked by 14 months
- Yes No Used single words by 18 months
- Yes No Is toilet trained
- Yes No **Developmental Concerns:** _____
- Yes No **Behavioral Concerns:** _____

Child goes to bed by: _____ PM Wakes at: _____ AM Naps: _____ hours per day

PREGNANCY / BIRTH HISTORY: (complete for Year 1 only)

- Yes No **Were there complications with the pregnancy or birth of this child?** **If yes, describe:** _____
- Yes No **Did mother use any medications, alcohol, street drugs or tobacco during pregnancy?** **If yes, describe:** _____
- Yes No **Did your child have any problems at birth or during first months of life?** **If yes, describe:** _____
- Yes No **Was your child born early (premature)?** **If yes, born at** _____ **gestation**

Please tell us anything else you would like us to know about your child's health: _____

Parent/Guardian Name (Please print clearly): _____ Parent Grandparent Foster Parent

Parent/Guardian Signature: _____ **Date:** _____

Reviewed by Preschool Nurse: _____ **Date:** _____

Special Health Conditions

Dear Parent or Guardian:

If your child has one of these conditions please inform the Enrollment Specialist who is assisting you:

- ❖ **ASTHMA** (*with or without medications*)
- ❖ **FOOD ALLERGY** (*i.e. peanut, seafood, etc.*)
- ❖ **HEART HISTORY**
- ❖ **SEIZURE HISTORY/DISORDER**
- ❖ **OTHER CONDITION:** _____

Specific paperwork needs to be completed by *you and your physician* before your child can attend class. We will happily provide you with the required paperwork.

Questions?

Please call the Nurse at your enrollment center:

- | | | |
|------------------|---------------------|------------------------------|
| • Cap City: | Lisa Stevens, RN | Ph: (916) 264-3950 ext. 1604 |
| • Hiram Johnson: | Lori Souza, RN | Ph: (916) 277-7047 ext. 1037 |
| | Victoria Benson, RN | Ph: (916) 277-7047 ext. 1035 |



Sacramento City Unified School District
CHILD DEVELOPMENT DEPARTMENT
SPECIAL CONCERN FORM

- Copy to Nurse
 Copy to Special Needs Coordinator

Child's Name: _____ Birthdate: _____ Program: EHS HS HB Wrap SP FD

Dear Parent: Please provide us with the following important information that will help your child have a safe and smooth transition into the classroom.

1. HEALTH - My child:

- Has a MEDICAL CONDITION (Such as Asthma, Food Allergies, Seizures, Diabetes, ADHD, Autism, etc.)
 No Yes – Please explain: _____
- Has MEDICATION PRESCRIBED BY A DOCTOR to be taken during school hours
 No Yes – Please explain: _____
- Requires a SPECIAL DIET due to a medical or allergy condition OR personal preference (Such as dairy-free, peanut-free, No pork, etc.)
 No Yes – Please explain: _____

2. SPECIAL NEEDS - My child:

- Receives or did receive SERVICES FOR SPECIAL NEEDS from the school district or other agencies (Such as, ALTA, SCOE, CCS, NOR-CAL, Easter Seals, Shriner's Hospital, etc.)
 No Yes – Please explain: _____
- Has been IDENTIFIED/ASSESSED FOR SPECIAL NEEDS
 No Yes – Please explain: _____
- Has an INDIVIDUAL EDUCATION PLAN (IEP) or INDIVIDUAL FAMILY SERVICE PLAN (IFSP)
 No Yes – Please explain: _____

3. TOILETING STATUS (Preschool only) - My child:

- Is in diapers or pull-ups

4. TOILETING READINESS (Preschool only) - My child:

- Needs ASSISTANCE WITH TOILETING
 No Yes – Please explain: _____

Office Use Only

All boxes checked No: File the WHITE copy of this form in the Child's Classroom File and the YELLOW copy in the Yellow Health Folder.

Any box checked Yes: The child's file is placed ON HOLD. If a health need is indicated, a copy is forwarded to the Nurse. If special needs are indicated, a copy is forwarded to the Special Needs Coordinator. The child's enrollment is pending until cleared by the Nurse and/or Special Needs Coordinator (except for Toileting Readiness). Enrollment eligibility status will not be affected; however, the child may not begin attending until cleared. File copies of the final form(s) in the Yellow Health Folder and Child's Classroom File.

HEALTH: Send this form & copy of Health History to Nurse. _____, _____
Date sent Office Technician

Child is cleared for attendance: Yes No Pending _____, _____
Date returned Nurse Signature

Comments: _____

SPECIAL NEEDS: Send this form & copy of IEP/IFSP to Special Needs Coordinator. _____, _____
Date sent Office Technician

Child is cleared for enrollment: Yes No Pending _____, _____
Date returned Special Needs Coordinator Signature

Comments: _____

TOILETING STATUS: Send a blank Toileting Plan to classroom teacher prior to child's enrollment if checked yes above.

Distribution: White Final copy of original - Yellow Health Folder and Child's Classroom File

Sacramento City Unified School District
Child Development Department

Head Start/Early Head Start TB* Risk Assessment

Child's Name: _____

DOB: _____

1	Has the child come in close contact with a person infected with tuberculosis (TB)?	Yes	No
2	Is the child foreign born, a refugee or a migrant?	Yes	No
3	Has the child had contact with an incarcerated person or a person who has been incarcerated in within the last 5 years?	Yes	No
4	Has the child been exposed to any of the following individuals: Homeless individuals, residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, migrant farm workers and/or those who have recently visited outside of the U.S.?	Yes	No
5	Does the child have a medical condition which suppresses the immune system?	Yes	No
6	Does the child live in a community in which it has been established that a high risk exists for TB?	Yes	No
7	Has the child traveled to any foreign countries since the last medical visit?	Yes	No

Parent/Guardian Signature: _____ Date: _____

Please note:

If you have answered "Yes" to any of the above questions, please refer to your child's Health Care Provider for possible TB testing.

*Tuberculosis (TB) is caused by a bacterium that usually infects the lungs, but the TB bacteria can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal. TB is spread through the air from one person to another by coughing, sneezing, speaking, or singing. People nearby may breathe in these bacteria and become infected. If you think you have been exposed to someone with TB disease, contact your health care provider or local health department to see if you should be tested for TB infection.

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT

Childhood Lead Poisoning Questionnaire

(A survey to determine a child's risk for lead poisoning)

- **Parent or Guardian:** Answer these questions about your child and give this form to his/her doctor.
Complete one survey for each child less than 6 years old.

Child's Name: _____ **Birthdate:** _____

Parent / Guardian - please answer below questions:

1. Does your child know someone who has lead poisoning (Blood lead level >15 ug/dL)? (For example, a parent, brother/sister, cousin, friend...)	Yes	No
2. Does your child live with someone who works with lead? (For example, person is a construction worker (fixes old houses), mechanic (fixes car batteries and radiators), works with scrap metal, solders (fixes) wires or electronics, makes ceramics/pottery/stained glass/jewelry...)	Yes	No
3. Do you have vinyl (plastic) miniblinds (vertical or horizontal) or old bath tubs in your home?	Yes	No
4. Does your child frequently put objects in his/her mouth and/or eat non-food items? (For example, child eats dirt, paint chips, chews on windowsills or fishing weights...)	Yes	No
5. Is your child anemic (lacking iron)? (Hemoglobin <11mg/dL or Hematocrit <33%)	Yes	No
6. Is your child given home remedies or wear make up from another country? <u>Common in these communities</u> <u>Home remedies/cosmetics</u> Latino Azarcon, Alarcon, Greta, Albayalde, Liza Maria, Hmong Luisa Coral, Rueda, Pay-loo-ah Arabic/Middle Eastern Kohl, Alkohol, Sattarang, Bokoor, Ceruse, Cerrusite, Asian-Indian Ghasard, Bala goli, Kandou, Surma	Yes	No
7. Does your child eat foods stored/cooked in old/imported pottery/dishes or eat Mexican candy?	Yes	No
8. Did your child live or spend some time in another country? Where and When?	Yes	No

➤ **Parent or Guardian**

- If you answered "Yes" to any of the questions, your child may be at risk for lead poisoning and needs a blood test.
- If you answered "No" to all the questions above, your child is not at risk for lead poisoning at this time.

*** Doctor: This child may need a blood lead test based on these risk/exposures to lead:**

- | | |
|---------------------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> On public assistance | <input type="checkbox"/> Child given home remedies |
| <input type="checkbox"/> In place built before 1978 or recently remodeled | <input type="checkbox"/> Child anemic |
| <input type="checkbox"/> Knows someone with lead poisoning | <input type="checkbox"/> Vinyl mini-blinds in home |
| <input type="checkbox"/> Pica behavior | <input type="checkbox"/> Uses old/imported pottery/dishes/candy |
| <input type="checkbox"/> Someone in home works with lead | <input type="checkbox"/> Lived in another country |
| | <input type="checkbox"/> Other _____ |

CHDP/Medi-cal Providers MUST:

Test child at 1 AND 2 years of age.
Test child if 2-6 years and never been tested for lead.

Parent/Guardian Signature: _____ Date: _____

Interviewer Name/Agency: : _____ Date: _____

CHILD CARE DATA COLLECTION PRIVACY NOTICE AND CONSENT FORM

The US Department of Health and Human Services (HHS) is gathering information about families that receive child care assistance. The information will be reported to the California Department of Education (CDE), and then to HHS. The information will be used for research on the status of child care in the United States, and will provide valuable data for those developing child care programs and policies at the state and local, as well as the national level.

All of the information HHS receives about your family and others will be summed up and reported to Congress every two years. No person or family will be individually identified in reports made to Congress or to the public. All information CDE receives about your family and others will be summed up, and no person or family will be individually identified in reports made to the Legislature, other governmental agencies or the public.

To ensure that children and families receiving child care services are counted only once, HHS and CDE are requesting the social security number of the head of the family unit receiving child care assistance. If you do not wish to give your social security number for this purpose, you may still receive child care assistance. Social security numbers will help us meet HHS reporting requests and state requirements for program statistics. Authority to ask for your social security number for this purpose is in Section 98.71(a)(13) of Title 45 of the Code of Federal Regulations, *Education Code* Section 8261.5, and Section 18070 of Title 5 of the California Code of Regulations. Your decision to provide your social security number is voluntary.

I have been informed of the way my social security number will be used.
I understand that if I do not wish to give my number, I can still receive
child care assistance.

YES, my social security number may be used: _____

NO, I do not wish to give my social security number for this purpose.

Signature of Head of Household

Date

Type of Print Name

If you would like a copy of this form, please ask.

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: River City Regional Office

Licensing Office Address: 2525 Natomas Park Drive, Suite 250
Sacramento, CA 95834

Licensing Office Telephone #: (916) 263-5744 FAX (916) 929-6371

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

(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

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

River City Regional Office

ADDRESS

2525 Natomas Park Drive, Suite 250

CITY

ZIP CODE

AREA CODE/TELEPHONE NUMBER

AREA CODE/FAX NUMBER

Sacramento

95834

(916) 263-5744

(916) 929-6371

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)

**Facing the Facts:
A Parent's Guide to the Understanding of *Child Abuse***

Definition of Child Abuse

As used in this article, "child abuse" means a physical injury which is inflicted by other than accidental means on a child by another person. "Child abuse" also means the sexual abuse of a child or any act or omission proscribed by Section 273a (willful cruelty of unjustifiable punishment of a child) or 273d (unlawful corporal punishment or injury.) "Child abuse" also means the neglect of a child or abuse in out-of-home care, as defined in this article. "Child abuse" does not mean a mutual affray between minors. Penal Code Section 11165.6

Definition of Sexual Abuse

As used in this article "sexual abuse" means sexual assault or sexual exploitation as defined in the following:
(a) "sexual assault" means conduct in violation of one or more of the following sections: Section 261 (rape), 264.1 (rape in concert), 285 (incest), 286 (sodomy), subdivision (a) or (b) of Section 288 (lewd or lascivious acts upon a child under 14 years of age), 288a (oral copulation), 289 (penetration of a genital or anal opening by a foreign object), or 647a (child molestation.) Penal Code Section 11165.1

Definition of Neglect

As used in this article, "neglect" means the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person Penal Code Section 11165.2

Contacts and Services

For your information, the following chart shows what agencies may assist you in the specific areas listed below:

	Police or Sheriff	County Dept of Children's Social Svc.	State or Local division of Community Care Licensing
If you believe a child is being (or has been) abused by an individual (relative, friend....)	✓	✓	
If you believe a child has been assaulted by a stranger...	✓		
If you believe a child is being (or has been) abused in a licensed day care setting (child care center, school, recreational facility, family day care home....)	✓		✓
If you have any questions or complaints concerning the licensing organization, staffing, or programs of a licensed child care setting...		✓	

Mandated Reporters

While everyone should report suspected child abuse and neglect, the California Penal Code provides that certain professionals and lay persons must report suspected abuse to the proper authorities. These include:

- Any child care custodian (teacher, licensed day care workers, foster parents, social workers)
- Medical Practitioners (physicians, dentists, psychologists, nurses)
- Non-medical Practitioners (public health employees, counselors, religious practitioners who treat children)
- Employees of a child protective agency (sheriff, probation officers, county welfare department employees)

If abuse is suspected a phone report to Police or CPS must be made immediately. Failure to submit the written report of suspected abuse by a mandated reporter (listed above) within 36 hours is a misdemeanor punishable by 6 months in jail and/or a \$1000 fine.

Child Abuse Prevention Curriculum

With your permission, your child will participate in a developmental safety program.

Remember, you have the primary responsibility for your child's well-being. With a little time, effort and understanding you may prevent your child from being abused or assist your child when abuse has occurred.

Child Abuse Prevention Information Receipt

This will acknowledge that I/we, the parents of _____ have received a copy of
Child's Name

"Facing the Facts: A Parent's Guide to the Understanding of Child Abuse" from the _____
Name of Facility

Signature of Parent(s)/Guardian(s) _____ Date _____



CHILD DEVELOPMENT

Dear Volunteer,

We are pleased that you have decided to participate in the Sacramento City Unified School District (SCUSD) Child Development Volunteer Program! As parents, grandparents, neighbors and community members you have valuable ideas, talents and time to share with our students and our schools.

It is our belief that our volunteer programs are beneficial to everyone involved. Volunteers help foster stronger school/community relationships by creating a common ownership in the success of our schools, as well as, demonstrating the importance of community service to our students.

The SCUSD Child Development Volunteer Program provides support and guidance to schools to help them facilitate their parent and community engagement programs. Currently, volunteers work in a variety of capacities: doing work from home; providing assistance in the classroom; participating on partnership advisory boards and assisting on field trips, etc.

This packet includes:

- Volunteer Registration Process
- Volunteer Registration and Code of Conduct Form (maintained at site with a copy to Volunteer Office)
- Volunteer Sex Offender Check Authorization (SOC-1 Rev.3/2010) Level II

Upon request:

- Volunteer Rules and Regulations – Excerpted from Administrative Regulations (AR 1240) and School Board Policy (BP 1240)

Registration Process:

In order to start volunteering, you need to have the following items on file with your school:

1. A current and completed volunteer registration and code of conduct form.
2. Copy of a recent TB Test or chest x-ray form/ card indicating a negative result.
3. A completed and cleared Volunteer Sex Offender Check Authorization Form (SOC-1)
4. Vetted volunteers must meet with school staff to review volunteer Rules and Regulations and site policy and procedures. **The Child Development Department will also offer a volunteer training. Dates TBA.**

If you have any questions, please direct them to BraJona Harris, Child Development Parent Advisor at (916) 643-7822.

Thank you,
Child Development
Sacramento City Unified School District



**SCUSD CHILD DEVELOPMENT
Volunteer Registration & Code of Conduct Form**

I. As a Volunteer, Your Role and Responsibilities in the Classroom Are Unique

- **Understand** that your role is a supportive one. The teacher is completely in charge. If the teacher leaves the room, you may not be left alone with children.
- **Maintain** student confidentiality at all times. Do not discuss any student with anyone except teachers.
- **Report** immediately to a staff person any abuse towards a student.

II. Volunteers Take Pride in Being Professional

- **Maintain** a constructive attitude. Don't make negative comments about the school, its personnel or the students to other volunteers or individuals outside the school.
- **Keep** an accurate record of your attendance.
- **Dress** and act professionally.
- **Never** be under the influence of alcohol or illegal drugs with students on or off school grounds.
- **Do not** smoke on school grounds or at any time around students.
- **Do not** use the internet inappropriately by going to websites that are not conducive to a professional or educational environment.
- **Do not** use cellphone in the classroom or at any time around students.

III. Health and Safety Are Always Important

- **Adhere** to district, school and classroom policies rules and regulations.
- **Refer** any student in need of first aid or any type of medication to the teacher.
- **Learn** and follow fire drill emergency procedures and all classroom/school rules.
- **Notify** the Coordinator of any accident you had on school grounds. An accident report form must be submitted to the Coordinator within 24 hours.

I agree to adhere to the above code of conduct at all times when I am a volunteer at a SCUSD school site or program. I understand that my volunteer status can be revoked at any time.

Volunteer Signature _____ **Date** _____

VOLUNTEERS PERSONAL INFORMATION:

First Name _____ Last Name _____

Date of Birth month _____ day _____ year _____

Home Address _____ City _____ Zip Code _____

Home Telephone (_____) _____ Cell Telephone (_____) _____

School Where I Will Be Volunteering _____

Student Name (if applicable) _____ Teacher/Room # _____

Agency or Organization (if applicable) _____

In Case of Emergency Notify: (Name and Phone Number) _____

OFFICE USE ONLY

- Verification of TB Clearance (Required)** Date of reading: _____
- Sex Offender Check (Required)** Date cleared: _____
- Parent Advisor Signature (Required)** Signature: _____



Instructions: This form is confidential.
Send original to BraJona Harris, Parent Advisor

Do not retain copy.

**VOLUNTEER SEX OFFENDER CHECK AUTHORIZATION
(SOC-1)**

Required for VOLUNTEER LEVEL II

FOR CHILD DEVELOPMENT SITE/PROGRAM _____

SIGNATURE OF PRINCIPAL/SUPERVISOR BraJona Harris, Child Development Parent Advisor

E-MAIL: BraJona-Harris@scusd.edu Phone: 643-7822

IMPORTANT: This form is for **VOLUNTEERS UNDER THE DIRECT SUPERVISION** of SCUSD certificated staff. There is no charge to sites to cover the costs of conducting a Sex Offender Check. *If the prospective volunteer will be assigned to a project for which fingerprinting is mandatory, do not have them complete this form. You must complete a Background Check Authorization (form BC-1) and send them to the SCUSD Human Resources Office at the Serna Center to be fingerprinted. If you have questions about which level of screening is required for a specific volunteer, please call 643-7924.*

Prior to beginning any assignment, SCUSD Board policy requires that all volunteers be cleared to work by the Department of Justice.

- *I understand this requirement and will not volunteer with the district until clearance is received from the SCUSD Human Resources Office.*
- *I have received a copy of district rules and regulations for volunteers [BP1240 and AR 1240]. Upon Request*
- *I hereby fully release and discharge the Sacramento City Unified School District, its officers, employees, agents and volunteers from any and all liability arising out of or in connection with this background check and all liabilities associated with and all claims related to this background check. For the purposes of this release, 'liability' means all claims, demands, losses, causes of action, suits or judgments of any and every kind that arise as a result of the above named activity and resulting from any cause other than gross negligence.*

Prospective Volunteer's Signature _____ **Date** _____

PLEASE PRINT NEATLY

Name (First/MI/Last) _____ Child's Name: _____

Other Names You have Been Known As: _____ Maiden Name _____

Date of Birth _____ / _____ / _____ Email Yes _____
Month Date Year May We Use This Email Account To Send Volunteer Updates?

Address _____ City _____ ZIP _____

Home Phone: _____ Cell phone: _____ Work: _____

A conviction may not necessarily disqualify you from the volunteer job for which you have applied. Convictions include diversionary offenses, or other offenses that have been plea-bargained, or for which you have pleaded no contest. **Failure to reveal convictions is grounds for immediate termination. Volunteer service may be terminated if service is unsatisfactory or no longer needed by the school district. District policy is available on the website: www.scusd.edu**

- Have you ever been convicted of a felony or misdemeanor? Yes _____ No _____
- If the answer is YES, please explain: _____



CHILD DEVELOPMENT DEPARTMENT
5735 47th Avenue, Box 715 • Sacramento, CA 95824
(916) 643-7800 • FAX (916) 399-2057

Dear Parent/Guardian:

Tuberculosis is an infectious disease which is spread through the air when a person infected with active TB coughs, speaks, sings, sneezes or spits. The only way to know for certain if you have been infected with TB is to be tested by a medical professional. A test commonly used to detect TB is the PPD skin test.

The Head Start Program mandates all Head Start parents/guardians and other volunteers to have a TB clearance on file with the preschool office. This requirement applies whether or not you participate in the classroom.

Our records indicate that you do not have a TB clearance on file; therefore, you are required to obtain one now. If you have a history of a positive skin test, documentation from your doctor or clinic of a negative chest x-ray is needed.

Give the results of your TB screening to your assigned office technician for your child's center.

If you decline to obtain your TB clearance, the statement at the bottom of this letter must be signed.

I understand that a TB clearance is required whether or not I participate in the classroom; however, I decline to obtain a TB test. I understand that by declining to obtain a TB clearance I am excluding myself from participating in my child's classroom.

Parent/Guardian Signature

Date

Print Parent/Guardian Name

Child's Name



Sacramento City Unified School District
CHILD DEVELOPMENT DEPARTMENT

- Check all that apply:**
- HS Part Day
 - State Preschool
 - HS Wrap
 - HS Home-based
 - FD Collaboration

FAMILY WORKSHEET

Child: _____ Birth Date: _____ M F Site: _____ AM PM

Parent / Legal Guardian(s): _____ , _____

Home Phone: _____ Other Phone: _____ English speaker: Yes No

If not, what language do you speak? _____ In what language do you prefer written material? _____

If you would like to receive information on a topic listed below, please check:

<input type="checkbox"/> Counseling <input type="checkbox"/> Stress Management <input type="checkbox"/> Child Discipline <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Child Abuse Prevention <input type="checkbox"/> Child Support Assistance <input type="checkbox"/> Incarcerated Parent Assistance <input type="checkbox"/> Marriage Support Assistance <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Medical/Dental _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> None of the above	Notes: _____	<input type="checkbox"/> Food <input type="checkbox"/> Clothing <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Utilities <input type="checkbox"/> Transportation Referral <input type="checkbox"/> GED/High School Diploma <input type="checkbox"/> Adult Education <input type="checkbox"/> College <input type="checkbox"/> ESL (<i>English as a Second Language</i>) <input type="checkbox"/> Job Training/Job Search <input type="checkbox"/> Special Education <input type="checkbox"/> Other: _____ <input type="checkbox"/> None of the above	Notes: _____
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In an effort to work cooperatively with other agencies, please check any services you are receiving.

<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> Energy Program Assistance	<input type="checkbox"/> Family Preservation
<input type="checkbox"/> *TANF/Cal Works	<input type="checkbox"/> General Assistance	<input type="checkbox"/> Probation
<input type="checkbox"/> Food Stamps	<input type="checkbox"/> Child Support/Alimony	<input type="checkbox"/> Unemployment Insurance
<input type="checkbox"/> Public Housing Assistance	<input type="checkbox"/> SCOE	<input type="checkbox"/> Supplemental Security Income (SSI)
<input type="checkbox"/> WIC	<input type="checkbox"/> ALTA Regional Center	<input type="checkbox"/> Other: _____
<input type="checkbox"/> *Have you established a TANF goal? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> None of the Above

What are your interests and strengths?

<input type="checkbox"/> Working with children	<input type="checkbox"/> Gardening	<input type="checkbox"/> Crafts
<input type="checkbox"/> Handy-work	<input type="checkbox"/> Sewing	<input type="checkbox"/> Music
<input type="checkbox"/> Painting	<input type="checkbox"/> First Aide	<input type="checkbox"/> Carpentry
<input type="checkbox"/> Planning/Organizing	<input type="checkbox"/> Storytelling	<input type="checkbox"/> Writing
<input type="checkbox"/> Cooking	<input type="checkbox"/> Security	<input type="checkbox"/> Photography
<input type="checkbox"/> Cosmetology	<input type="checkbox"/> Retail Services	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Computers	<input type="checkbox"/> Typing	<input type="checkbox"/> None of the Above

Parent/Legal Guardian Signature: _____ Male Female Date: _____

Parent/Legal Guardian Signature: _____ Male Female Date: _____

I have received the "Community Resources" handout. (Please Initial): _____

For 1st Home Visit

I have reviewed the Family Worksheet with Teacher/School Community Liaison (SCL). _____
 Parent's Initial and Date

Teacher/School Community Liaison (SCL)/Home Visitor Signature: _____ Date: _____

Family would like follow-up from Resource Staff: YES NO

Distribution: White – Child's File Yellow – SCL / Central Support Staff Pink – Parent



Child Development Department Community Resources/Recursos de la Comunidad

InfLine Sacramento 2-1-1 or 498-1000

www.211sacramento.org
www.HealthyCity.org
www.onefatherslove.com

Child Abuse Prevention/Prevenir Abuso de niños

Child Protective Services (CPS).....875-5437
 Sacramento Crisis Nursery.....394-2000

Child Discipline-Disciplina de Niños

Parent Support Line1-888-281-3000

Child Support Assistance/Apoyo de Niños

Sacramento County Department of Child Support Services.....
 866-901-3212
 Superior Court of California-Family Law Facilitator.....
875-3400

Clothing/Ropa

SCUSD PTA Clothes Closet.....643-2362
 (Referral needed from school office)
 Sacramento Food Bank & Family Services.....456-1980

Counseling/Consejería

Sacramento County Access Adult Counseling Services 875-1055
 La Familia Counseling Center452-3601
 Hmong Women's Heritage.....394-1405
 River Oak Family Resource Center244-5800

Domestic Violence/Violencia Domestica

WEAVE448-2321
 WEAVE (24 Hour Crisis Line)920-2952
 My Sisters House.....428-3271

Adult Education/College/Educación/Colegio

Charles A. Jones Center433-2600
 Los Rios Community College District.....568-3041

Food/Comida

Sacramento Food Bank & Family Services 456-1980
 CalFresh874-3100
 Women, Infants and Children (WIC).....876-5000
 River City Food Bank.....446-2627

Emergency Shelter/Alojamiento de Emergencia

SCUSD Office of Homeless Services.....277-6892
 Sacramento Area Emergency Housing Center.....455-2160
 Salvation Army Emergency Shelter442-0331
 St. Johns Shelter for Women & Children.....453-1482

Health/Dental/Salud

CHDP875-7151
 Sacramento Covered414-8333
 WellSpace Health (Medical)646-8000
 WellSpace Dental.....233-4925

Parent Legal Assistance/Asistencia-legal para padres de la familia

Family Law, Self-Help Center875-3400
 Legal Services.....551-2100

Job Training/Entrenamiento de Trabajo

Sacramento Works263-3800
 Asian Resources.....454-1892

Marriage Support Assistance/Asistencia con Apoyo Cónyuge

Relationship Skills Center362-1900

Special Needs/Educación Especial

Warmline Family Resource Center922-9276
 SCUSD Special Education Department643-9174
 Alta California Regional Center.....978-6400
 SCOE Sacramento County of Education228-2386

Substance Abuse/Abuso de Substancia

Sacramento County Access Alcohol & Drug Counseling
 Program874-9754
 Alcoholics Anonymous454-1100
 Narcotics Anonymous.....1-877-623-6363

Transportation Assistance/Transportación

Sacramento Regional Transit.....321-2877

Utility Assistance/Utilidades

Community Resource Project (HEAP).....567-5200
 PG & E CARE Program1-866-743-2273
 SMUD Energy Assistance Program1-888-742-7683
 California Lifeline.....1-866-272-0357