Preschool
Continuation Packet Checklist

If you are looking to continue preschool services through our program, please complete the attached packet and return to Capital City Child Development Center located at 7220 24th Street or Hiram Johnson Family Education Center located at 3535 65th Street. Please bring in your *current paycheck stubs for the last month (30 days)*, a copy of your PG&E or SMUD bill if your address has changed, and a copy of your child's latest physical and dental examination. If you are second year returning, Head Start parent, income is not required.

This packet includes:

- ☐ Emergency Card
- ☐ Health and Development History, 2nd Year
- ☐ Parent/Guardian Notification and Consent Form
- ☐ Special Concerns Form
- ☐ TB Risk Assessment
- ☐ Lead Poisoning Questionnaire
- ☐ Child Abuse Reporting
- ☐ Notification of Parent Rights
- ☐ Personal Rights Form
- ☐ Family Worksheet
- ☐ Parent TB Waiver
- ☐ Physical form
- ☐ Dental form

If you have any questions, please call Capital City Child Development Center at (916) 433-2736 or Hiram Johnson Family Education Center at (916) 277-7151.

Non-Discrimination Policy - The Sacramento City Unified School District does not discriminate on the basis of race, color, national origin, age, religion, political affiliation, gender, gender expression, gender identity, mental or physical disability, sexual orientation, parental or marital status, or any other basis protected by federal, state, or local law, ordinance or regulation, in its educational program(s) or employment.

Sacramento City Unified School District

Complete All Information on Both Sides

EMERGENCY CARD (revised 7/19/12)

CONFIDENTIAL

Student Information

Please Print

Student's Last Name (Legal) _____ First Name _____ Middle _____

Street Address _____ Apt # _____ Zip Code _____

Home Phone (1) _____ Home Phone (2) _____

LANUAGE SPOKEN AT HOME:

School Year

School

Date of Birth

Office Use Only

Teacher/Cnslr. _____

Grade _____ Room _____ Bus _____

CONCAP [ ] Hm. Sch. _____

Sp. Ed. [ ] RSP [ ] Eth. Cd [ ]

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):

_____

_____

_____

_____

CONTINUE ON REVERSE SIDE

Sacramento City Unified School District
Complete All Information on Both Sides

EMERGENCY CARD (revised 7/19/12)
CONFIDENTIAL

Student Information
Please Print

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:

☐ ADD/ADHD
☐ Asthma
☐ Diabetes ☐ Type I ☐ Type II
☐ Frequent ear infections
☐ Eczema
☐ Fainting Spells
☐ Frequent Headaches
☐ Heart Problems
☐ Seasonal Allergy
☐ Frequent nosebleeds
☐ Seizures
☐ Severe Allergy
☐ 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** _____

CONTINUE ON REVERSE SIDE

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 of 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:** _____

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.

_____ *Initials* 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)

_____ *Initials* 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.

_____ *Initials* 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:
   ☐Yes ☐No Hearing/Vision ☐Yes ☐No Height/Weight ☐Yes ☐No Social/Emotional
   ☐Yes ☐No Speech/Language ☐Yes ☐No 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
   ☐Yes ☐No
3. Assessment: — I consent to have my child participate in preschool assessments.
   ☐Yes ☐No
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.
   ☐Yes ☐No
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
   ☐Yes ☐No
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).
   ☐Yes ☐No

Parent/Guardian

Print:_____ **Sign:** _____ **Date:** _____

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

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.

Childhood Lead Poisoning Prevention Questionnaire

PARENT OR GUARDIAN: This is a survey to help determine your child's risk for lead poisoning. Please answer these questions about your child and give this form to his/her doctor. Complete one survey for each child.

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

1. Does your child live in, or spend a lot of time in, a place built before 1978 that has peeling or chipped paint or that has recently been renovated? *For example*, school, daycare, baby-sitter, family, friend or neighbor's home.	Don't Know	Yes	No
2. Does your child know someone who has or has had lead poisoning? *For example*, a parent, sibling, cousin or friend.		Yes	No
3. Does your child live with someone who works with lead? *For example*, a person who is a construction worker or painter; car mechanic; works with metal; works as an electrician or with electronics; makes ceramics, pottery, stained glass or jewelry.		Yes	No
4. Does your child live with someone who likes to hunt, shoot guns, fish or melt lead fishing weights?		Yes	No
5. Does your child frequently put objects in his/her mouth and/or eat non-food items? *For example*, child eats dirt, paint chips or chews on windowsills.		Yes	No
6. Is your child anemic or has she or he been prescribed iron pills/liquid?		Yes	No
7. Has your child ever been given home remedies or has she or he ever worn cosmetics from another country?		Yes	No

Region/Community	Home Remedies/Cosmetics
Arabic/Middle Eastern	Surma/Kohl, Espend, Goty, Zachoba, Zagafel, Khakshir, Alkohl, Sattarang, Bokoor, Ceruse, Cerrusite
Asian-Indian	Surma, Sindoor, Ghasard, Bala goli, Kandu
Hmong	Pay-loo-ah
Latino	Azarcon, Alarcon, Greta, Albayalde, Liza Maria, Luisa Coral, Rueda
Other: _____	*Other:* _____

8. Does your child eat foods stored or cooked in old or imported pottery/dishes or lead crystal?	Yes	No
9. Does your child eat candies imported from Mexico or Asia; Kurut yogurt imported from Afghanistan; or eat imported spices like chili, turmeric, or ginger?	Yes	No
10. Has your child lived in or spent time in another country? If so, where and when?	Yes	No
11. Is your child receiving services from any publicly-funded programs such as from Head Start, Medi-Cal or WIC?	Yes	No

PARENT OR GUARDIAN:
If you answered "Yes" to any of the questions, your child may be at risk for lead poisoning and may need a blood lead test. Please ask your child's doctor for a blood lead test at his or her next check-up.

HEALTH CARE PROVIDER:
This child may need a blood lead test based on the risk factors identified above.

Health Assessment Guidelines

1) Perform a risk assessment on children beginning at 6 months of age and screen (*blood test*) as indicated.
*Testing is required if child is participating in publicly-funded programs and Question 1 is answered as **Yes** or **Don't Know**, or other risks are identified.

2) Screen (*blood test*) children at 1 **and** 2 years of age if identified as at risk.

3) Screen child if 2 - 6 years old and has never been tested for lead and if identified as at risk.

Interviewer Name/Agency:_____ **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 Practitiioners (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 Facitlity

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

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(Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' R I G H T S
(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)

Confidential

Sacramento City Unified School District
CHILD DEVELOPMENT DEPARTMENT

FAMILY WORKSHEET

Check all that apply:
- ❑ HS Part Day
- ❑ State Preschool
- ❑ HS Wrap
- ❑ HS Home-based
- ❑ Children's Center

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:

	Notes:		Notes:
☐ Counseling		☐ Food	
☐ Stress Management		☐ Clothing	
☐ Child Discipline		☐ Emergency Shelter	
☐ Substance Abuse		☐ Utilities	
☐ Child Abuse Prevention		☐ Transportation Referral	
☐ Child Support Assistance		☐ GED/High School Diploma	
☐ Incarcerated Parent Assistance		☐ Adult Education	
☐ Marriage Support Assistance		☐ College	
☐ Domestic Violence		☐ ESL *(English as a Second Language)*	
☐ Medical/Dental _____		☐ Job Training/Job Search	
☐ Other: _____		☐ Special Education	
☐ None of the above		☐ Other: _____	
		☐ None of the above	

In an effort to work cooperatively with other agencies, please check any services you are receiving.

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

What are your interests and strengths?

☐ Working with children	☐ Gardening	☐ Crafts
☐ Handy-work	☐ Sewing	☐ Music
☐ Painting	☐ First Aide	☐ Carpentry
☐ Planning/Organizing	☐ Storytelling	☐ Writing
☐ Cooking	☐ Security	☐ Photography
☐ Cosmetology	☐ Retail Services	☐ Other: _____
☐ Computers	☐ Typing	☐ 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 & Date

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

Family would like follow-up from Resource Staff: ☐ Yes ☐ No

Notes:

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

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

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:** _____

R E Q U I R E D (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: _____

R E Q U I R E D (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

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; NaFl 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:** _____

Sacramento City Unified School District
CHILD DEVELOPMENT DEPARTMENT

PRESCHOOL DENTAL HEALTH / EXAM RECORD

Child's Name: _____ Birthdate: _____ M___ F___

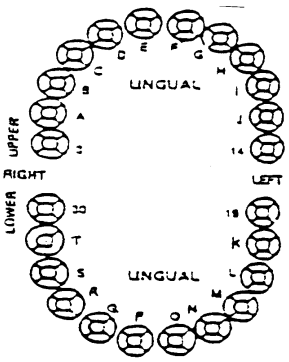
Parent/Guardian Name: _____ Phone: _____

Address: _____

I authorize professionally qualified people to exchange information about my child. I understand that all information will be kept in a confidential file.

Parent/Guardian Signature: _____ Date: _____

DENTAL PROVIDER:



PLEASE LIST ALL SERVICES PROVIDED BELOW AND COMPLETE SUMMARY:

Date of Service	Tooth # or Letter	Description of Services Provided

SUMMARY:
- ☐ No Treatment Needed
- ☐ Preventive Care Given
- ☐ Specialist Referral Given _____
- ☐ Dental Treatment Received
- ☐ Approx. # of visits needed _____
- Next Appointment Date _____

Dentist: _____ _____ _____
(Please print) (Signature) (Date)

Address: _____ Phone: (_____)_____

If treatment is not complete at this visit, please fill out a new form for each additional visit until treatment is completed.
Please return completed forms to: (PLEASE CHECK ONE)

☐ Child Development Department
Capital City Registration Center
7220 - 24th Street, Sacramento, CA 95822
(916) 433-2736 **Fax: (916) 433-2738**

☐ Child Development Department
Hiram Johnson Family Education Center
3535 65TH Street, Sacramento, CA 95820
(916) 277-7151 **Fax: (916) 277-6698**

For SCUSD Nurse Use Only:

- ☐ Dental Exam ☐ Pass/☐ Fail
- ☐ Preventive Dental Care Given
- ☐ Treatment given: _____
  - ☐ Treatment In-Process
  - ☐ Treatment Completed
- ☐ Approx. # of Visits Needed: _____
- ☐ Referred to Specialist: _____

Data Entry (initials/date): _____