RIALTO UNIFIED SCHOOL DISTRICT
District Enrollment Center
260 South Willow Avenue, Rialto CA 92376
(909) 873-4300 Fax: (909) 873-4301
Email: preschool@rialtousd.org

Preschool Enrollment Checklist

Qualification for State Preschool is income based. Rialto U.S.D. offers preschool programs for those families who do not qualify based on their income. ** Space is limited.

Please provide the following documentation:

- ☐ Verification of income for each working parent in the home (income for the last 30 days)
- ☐ CalWorks/ Cash Aid Assistance/ CalFresh/ Adoption or Foster Care Assistance (If applicable)
- ☐ Birth Records for **ALL** children under your care (to determine family size)
- ☐ Immunization record
- ☐ Current Physical Exam (form included in the packet)
- ☐ T.B. Test with results or Risk Assessment
- ☐ Photo I.D. of the enrolling parent/guardian
- ☐ Proof of Address dated within 30 days

Only complete packets will be accepted

RIALTO UNIFIED SCHOOL DISTRICT ENROLLMENT FORM - PRESCHOOL

STUDENT INFORMATION (please use blue or black ink)

Legal Last Name	Legal First Name	Legal Middle Name

Grade	Also Known As (other names used)

Address	Apt./Space	☐ Rialto ☐ San Bernardino ☐ Fontana ☐ Colton ☐ Other _____	Zip Code

Mailing address, if different	Apt./Space	☐ Rialto ☐ San Bernardino ☐ Fontana ☐ Colton ☐ Other _____	Zip Code

Primary Phone Number	Date of Birth	Sex ☐ Male ☐ Female	Preferred Language of Correspondence

Primary Email

ETHNICITY (Please select one)
Is your child Hispanic or Latino?
☐ Yes, Hispanic or Latino
☐ No, Not Hispanic or Latino

RACE (Please select all that apply)
☐ American Indian or Alaska Native (Origins in North, Central or South America)
☐ African American or Black ☐ Cambodian ☐ Chinese ☐ Filipino/Filipino American ☐ Guamanian
☐ Hawaiian ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Other Asian ☐ Other Pacific Islander
☐ Samoan ☐ Tahitian ☐ Vietnamese ☐ White (Origins in Europe, North Africa, or the Middle East)

FAMILY INFORMATION (If there is a custody/restraining order for your child, please provide copy)

Name of Person Enrolling Student	**Relationship to student** ☐ Mother ☐ Father ☐ Caregiver ☐ Foster Parent ☐ Legal Guardian	Phone Number / Work Phone

Name of Legal Mother	☐ Lives with ☐ Not in the home	Phone Number / Work Phone

Name of Legal Father	☐ Lives with ☐ Not in the home	Phone Number / Work Phone

CHILDREN LIVING UNDER YOUR CARE

Name	Date of Birth	School
Name	Date of Birth	School
Name	Date of Birth	School

PREVIOUS SCHOOL INFORMATION (List last school first)

Name of School	City	State	Grade	School Year

Has the student attended a Rialto USD school? ☐ Yes ☐ No (ex. Preschool)
If yes, name school: Grade: School Year:

PARENT EDUCATION LEVEL

The California State Department of Education requests information regarding the highest level of education completed by the enrolling parent/guardian. Please check for both parents.

Mother/Guardian 1
☐ Not a high school graduate ☐ High school graduate
☐ Some College ☐ College graduate
☐ College degree from a 4 year university with additional coursework in graduate school

Father/Guardian 2
☐ Not a high school graduate ☐ High school graduate
☐ Some College ☐ College graduate
☐ College degree from a 4 year university with additional coursework in graduate school

PRIOR SPECIAL EDUCATION PROGRAMS

Please provide the following information for student placement in a special service or program:

☐ My child has **NOT** participated in a special program
☐ My child has an IEP, IFSP, ISP, or 504 Plan

My child receives the following services outside of Rialto USD:
☐ Specialized Academic Instruction (ex. RSP/SDC)
☐ Speech Therapy
☐ Occupational Therapy
☐ Adaptive Physical Education
☐ Physical Therapy
☐ Other: _____

Do you have any concerns about your child? _____

OFFICE USE ONLY

Notes:

Grade: _____

Date: _____

Student #: _____

School of Residence: _____

School Assigned: _____

Start Date: _____

Teacher: _____

Classroom/AM or PM: _____

Birth Verification: _____

P.O.B: _____

Enter Code: _____

Address Verification:
☐ Utility/Rent Receipt
☐ Affidavit of Residence
☐ Other: _____
☐ McKinney Vento
☐ Foster
4-digit zip: _____

☐ RPAT
Emailed: _____
Placement Received: _____

Enrolled by: _____

My signature certifies that all information provided is accurate. I understand that changes in address, telephone numbers, and/or emergency information must be reported to the school within 24 hours for the safety of my student.

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

2/2024

Housing Questionnaire

The information provided below will help your child's school to determine whether you and/or your child may be eligible for specialized services and supports. This could include additional educational services through Title I, Part A and/or the federal McKinney-Vento Assistance Act. The information provided on this form will be kept confidential and only shared with appropriate school district and site staff.

Student Name	**Date of Birth**
School Assigned	**Grade**

Which of the following describes you and/or your family's current living situation? *Please check all that apply.*

- ☐ **Sharing housing** with other(s) due to loss of housing, economic hardship, natural disaster, lack of adequate housing, or similar reason
- ☐ Staying in a **shelter** (family shelter, domestic violence shelter, youth shelter) or Federal Emergency Management Agency (FEMA) trailer
- ☐ Living in a car, park, campground, abandoned building, or other inadequate accommodations (i.e. lack of water, electricity, or heat)
- ☐ Temporarily living in a **motel or hotel** due to loss of housing, economic hardship, natural disaster, or similar reason
- ☐ I am a student under the age of 18 and **living apart from parent(s) or guardian**

☐ **None of the above**. My student and I live in permanent, adequate housing

The undersigned parent/guardian certifies that the information provided above is correct and accurate.

Parent/Guardian Name (Print) _____ **Parent/Guardian Signature** _____ **Date** _____

Street Address _____ **City** _____ **State** _____ **Zip Code** _____ **Phone Number** _____

Your child or children may have the right to:

- Immediate enrollment in the school they last attended (school of origin) or the local school where you are currently staying, even if you do not have all the documents normally required at the time of enrollment.
- Continue to attend their school of origin, if requested by you and it is in the best interest.
- Receive transportation to and from their school of origin, the same special programs and services, if needed, as provided to all other children, including free meals and Title I.
- Receive the full protections and services provided under all federal and state laws, as it relates to homeless children, youth, and their families.

Please list all children currently living with you.

Name	**Birthdate**	**Grade** (if applicable)	**School** (if applicable)

If you have any questions about these rights, please contact your school site's homeless youth representative. If you have trouble contacting them, you may contact the Rialto USD McKinney-Vento & Foster Youth Liaisons at 909-873-4336.

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Authorization to Release Information (Parent 1)

I, _____, parent of _____ give authorization for
(Employee Name) (Student's Name)

Rialto Unified School District – Early Education, to verify all information utilized to determine my family's eligibility during the time I am enrolled in their program.

I authorize the sharing of information between agencies to verify my income, and eligibility. Agencies that may be contacted include, but are not limited to, the Department of Public Social Services, Department of Child Support, training sites, schools, social service agencies, referring physicians, emergency shelters, and employers.

I declare under penalty of perjury that all information that I provided to Rialto USD – Early Education is true and correct, and that all documents submitted to Rialto USD – Early Education, are to the best of my knowledge true and correct. Failure to comply with these rules will result in termination from the Rialto USD – State Preschool Program.

_____ _____ _____
Employee/Parent Signature Employee ID # Date

EMPLOYMENT/ INCOME VERIFICATION

This is a State funded preschool program and therefore we must have confirmation of all income and work hours of parents whose children are enrolled in our program. Please release the following information for our records. All information is confidential, and used only for family eligibility purposes.

_____
Name of Employee Phone

_____
Home Address City State Zip code

_____
Name of Employer Contact Person

_____
Employer/ Work Address City State Zip code

Employer Phone _____ Employer Email _____

Hire Date _____ Work Hours: Start_____End_____Job Title_____

Days of Employment: Sun_____Mon_____Tue_____Wed_____Thurs_____Fri_____Sat_____

Pay Schedule: ❒ Weekly ❒ Bi-Weekly ❒ Twice a Month ❒ Monthly **Gross Salary (Per Pay Period) $**_____

Note if flexible schedule: Hourly Rate $_____ Minimum hours per week_____ Maximum hours per week_____

I affirm that, to the best of my knowledge, the above information is true and correct:

_____
SIGNATURE OF EMPLOYER DATE

OFFICE USE ONLY

Information obtained by:

☐	Telephone	Phone No: _____	Name: _____
☐	Facsimile	Fax No: _____	Name: _____
☐	E-Mai/ U.S.Mail	_____	Name: _____

Notes: _____
Date: _____ Verified by: _____

RIALTO UNIFIED SCHOOL DISTRICT
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(909) 873-4300 Fax: (909) 873-4301

Authorization to Release Information (Parent 2)

I, _____, parent of _____ give authorization for
(Employee Name) (Student's Name)

Rialto Unified School District – Early Education, to verify all information utilized to determine my family's eligibility during the time I am enrolled in their program.

I authorize the sharing of information between agencies to verify my income, and eligibility. Agencies that may be contacted include, but are not limited to, the Department of Public Social Services, Department of Child Support, training sites, schools, social service agencies, referring physicians, emergency shelters, and employers.

I declare under penalty of perjury that all information that I provided to Rialto USD – Early Education is true and correct, and that all documents submitted to Rialto USD – Early Education, are to the best of my knowledge true and correct. Failure to comply with these rules will result in termination from the Rialto USD – State Preschool Program.

_____ _____ _____
Employee/Parent Signature Employee ID # Date

EMPLOYMENT/ INCOME VERIFICATION

This is a State funded preschool program and therefore we must have confirmation of all income and work hours of parents whose children are enrolled in our program. Please release the following information for our records. All information is confidential, and used only for family eligibility purposes.

_____
Name of Employee Phone

_____
Home Address City State Zip code

_____
Name of Employer Contact Person

_____
Employer/ Work Address City State Zip code

Employer Phone _____ Employer Email _____

Hire Date _____ Work Hours: Start_____End_____Job Title_____

Days of Employment: Sun_____Mon_____Tue_____Wed_____Thurs_____Fri_____Sat_____

Pay Schedule: ❒Weekly ❒Bi-Weekly ❒Twice a Month ❒Monthly **Gross Salary (Per Pay Period) $**_____

Note if flexible schedule: Hourly Rate $_____ Minimum hours per week_____ Maximum hours per week_____

I affirm that, to the best of my knowledge, the above information is true and correct:

_____
SIGNATURE OF EMPLOYER DATE

OFFICE USE ONLY

Information obtained by:

□	Telephone	Phone No: _____	Name: _____
□	Facsimile	Fax No: _____	Name: _____
□	E-Mai/ U.S.Mail	_____	Name: _____

Notes: _____
Date: _____ Verified by: _____

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Self-Certification of Unemployed

I am currently:

- ☐ Seeking employment (Not receiving unemployment benefits)
- ☐ Stay at home Mom or Dad
- ☐ Full or Part time student
- ☐ Other (brief explanation):

_____

_____

_____

_____

I, _____, swear under penalty of perjury, to the
(Parent Name)
best of my knowledge, that the information is true and correct.

_____ _____

Signature Date

RIALTO UNIFIED SCHOOL DISTRICT
EARLY EDUCATION
260 South Willow Avenue, Rialto, CA 92376
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Applicants for Early Education Preschool Programs

NOTIFICATION OF DISTRICT MISREPRESENTATION POLICY

The California Department of Education, Early Education Division, requires the Office of Early Education to inform all families receiving services funded by Early Education, of the Rialto Unified School District Misrepresentation Policy.

The information I have provided to the Rialto Unified School District verifying my income in order to qualify for specific early education preschool services is correct. I understand that all cases of misrepresentation will be referred to the Office of the San Bernardino County District Attorney.

Parent / Applicant's Name

Student Name

Parent / Applicant's Signature

Date

Student Name: _____

Rialto Unified School District

Custody Issues

Parent Disputes over Custody in School Setting

Parents may try to use the school as a forum for disputing custody matters. If needed, the school district may consider including the following form in their annual notification to parent and legal guardians.

Custody disputes must be handled by the courts. The school has no legal jurisdiction to refuse a biological parent access to their child. The only exception is when a signed restraining order or proper divorce papers, specifically stating visitation limitations, are on file in the school office. Any student release situation which leaves the student's welfare in question will be handled at the discretion of the site administrator or designee. Should any such situation become a disruption to the school, law enforcement will be contacted and an officer requested to intervene. Unless Educational Rights have been revoked, both parents have access to student records.

Parents are asked to make every attempt not to involve school sites in custody matters.

The school will make every attempt to reach the custodial parent when a parent or any other person not listed on the emergency card attempts to pick up a child.

I have read and understand the above statement.

_____

Parent/Guardian Signature 1 Date

_____

Parent/Guardian Signature 2 Date

Office use only:

Date Received: _____ Home School: _____

Notification placed on Synergy: _____ Document(s) uploaded to Synergy: _____

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME | SEX | BIRTH DATE

FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME | DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?

MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME | DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?

IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN? | DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT* MONTHS | BEGAN TALKING AT* MONTHS | TOILET TRAINING STARTED AT* MONTHS

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

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO | HOW MANY IN LAST YEAR? | LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?* | WHAT TIME DOES CHILD GO TO BED?* | DOES CHILD SLEEP WELL?*

DOES CHILD SLEEP DURING THE DAY?* | WHEN?* | HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)
BREAKFAST
LUNCH
DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST
LUNCH
DINNER

ANY FOOD DISLIKES? | ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO | IF YES, AT WHAT STAGE:* | ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO | WHAT IS USUAL TIME?*

WORD USED FOR "BOWEL MOVEMENT"* | WORD USED FOR URINATION*

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO | IF YES, NAME OF DOCTOR: | DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO | IF YES, WHAT KIND AND ANY SIDE EFFECTS:

DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO | IF YES, WHAT KIND: | DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO | IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

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

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

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

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

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE | DATE

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME
Community Care Licensing

ADDRESS
3737 Main Street, Suite 700

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Riverside	92501	(951) 782-4200

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)
Preschool Site:	

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

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

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

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

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Community Care Licensing

   Licensing Office Address: 3737 Main Street, Suite 700, Riverside, CA 92501

   Licensing Office Telephone #: (951) 782-4200

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

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

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

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

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

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

_____
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

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

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

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EARLY EDUCATION
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(909) 873-4300 Fax: (909) 873-4301

Child's Name_____ **D.O.B**_____ **Site**_____

(Please initial next to each statement)

_____ **PERSONAL RIGHTS**
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.

_____ **PARENT'S RIGHTS**
I/We have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENT'S RIGHTS" form from the licensee.

_____ **PARENT PARTICIPATION**
I understand a parent representing my child is encouraged to participate in the preschool program each month.

_____ **ATTENDANCE PROCEDURES**
I understand the person(s) authorized to pick up or drop off my child must be 18 years of age or older. Authorized persons **must** also be listed on child's emergency card and are able to present a photo ID upon request. My child will not be released to anyone not listed on the emergency card. **NO VERBAL AUTHORIZATIONS WILL BE ACCEPTED.**

_____ **I understand my child is expected to attend preschool each day, Monday through Friday for the entire 3 hours. I further understand my child must be dropped off and picked up on time every day.**

_____ I understand that I may ask the preschool office for help in locating social services to help my child or my family.

_____ **CONDITIONS FOR TERMINATION**
Students may be terminated from the preschool program for 10 or more absences, 3 or more unexcused absences or because Students and /or their parent become abusive, jeopardizing the physical, mental, or emotional health of children or employees. The state preschool program shall be a safe environment, for all students and staff. Also, my child may be terminated due to 3 or more late drop-offs and/or early or late pick-ups.

_____ **ANIMAL CONSENT**
Throughout the school year we may have animals in the preschool classroom. We will have them either for observation purposes for an instructional unit or as a class pet for students to develop the responsibility of caring for pets. Students are always interested in petting and handling the animals that visit as well as caring for pets. Students are taught how to safely and carefully handle the animals. Please indicate if you DO or if you DO NOT want your child to participate by handling and caring for the animal.

_____ **Yes**, my child may handle the animals that will be in the class.

_____ **No**, I do not want my child to handle any of the animals that will be in the class.

_____ **STUDENT RECORDS**
When your child moves on to kindergarten or transfers to a different preschool in Rialto Unified School District, your child's teacher will forward your child's records to the new teacher. These will include information about your child's development progress, student work samples, and emergency contact information. *It will **not** include: the personal financial records you submitted to qualify for the State Preschool Program.*

_____ _____
Signature of Parent or Guardian **Date**

RIALTO UNIFIED SCHOOL DISTRICT
HEALTH SERVICES
815 S. Willow Ave., Rialto, CA 92376 • Tel (909) 820-8150 • Fax (909) 820-8151

STUDENT HEALTH HISTORY

Student Name: _____ **Date of Birth:** _____ **Grade:** _____

☐ **My child does NOT have any known health conditions**

☐ **My child has the following health conditions:**
(check all that apply **and** if medication or treatment is required at school)

	Medication / Treatment REQUIRED at school
☐ Allergies Type of allergy: _____ Type of Medication: _____	☐ Yes ☐ No
☐ ADHD / ADD	☐ Yes ☐ No
☐ Asthma	☐ Yes ☐ No
☐ Autism	☐ Yes ☐ No
☐ Birth Defects / Genetic Disorders	☐ Yes ☐ No
☐ Blood / Bleeding Disorders	☐ Yes ☐ No
☐ Hearing Loss	☐ Yes ☐ No
☐ Kidney Disorder / Bladder Problems	☐ Yes ☐ No
☐ Psychological Problems	☐ Yes ☐ No
☐ Serious accidents or hospitalizations	☐ Yes ☐ No
☐ Vision Impairment	☐ Yes ☐ No
☐ **Cancer / Leukemia**	☐ Yes ☐ No
☐ **Cerebral Palsy**	☐ Yes ☐ No
☐ **Colostomy Bag**	☐ Yes ☐ No
☐ **Diabetes:** ☐ **Type 1** ☐ **Type 2 – Insulin Dependent:** ☐ Yes ☐ No **If applicable:** ☐ Dexcom ☐ Insulin Pump ☐ Metformin ☐ Humalog Insulin Pen	☐ Yes ☐ No
☐ **Epilepsy / Seizures –** ☐ Requires Diastat	☐ Yes ☐ No
☐ **Gastrostomy Tube (G-Tube) –** ☐ Requires G-Tube feeding	☐ Yes ☐ No
☐ **Heart Problems / Heart Surgery**	☐ Yes ☐ No
☐ **Tracheostomy** ☐ Requires Suctioning ☐ Ventilator Dependent ☐ Oxygen Dependent	☐ Yes ☐ No
☐ **Other:** _____	☐ Yes ☐ No

Special Treatments and/or Medications: _____

_____

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

OFFICE USE ONLY

Emailed Health Services: _____ Verified by Health Services: _____ School: _____

Provided parent with the following documents:

☐ Authorization for Medical Release ☐ Medication Form

CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE
( )

WORK PHONE
( )

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____. This Child Care Center/School provides a program which extends from _____ : ____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

Parents' Guide to Immunizations

Required for Pre-Kindergarten (Child Care)

Parents must show their child's Immunization Record as proof of immunizations (shots) before starting pre-kindergarten (child care) and at each age checkpoint after entry:

Age at Entry/checkpoint	Required Doses
2–3 Months	**1 Polio** **1 DTaP** **1 Hep B** **1 Hib**
4-5 Months	**2 Polio** **2 DTaP** **2 Hep B** **2 Hib**
6-14 Months	**2 Polio** **3 DTaP** **2 Hep B** **2 Hib**
15-17 Months	**3 Polio** **3 DTaP** **2 Hep B** **1 Hib*** (on or after 1st birthday) **1 Varicella** **1 MMR** (on or after 1st birthday)
18 Months–5 Years	**3 Polio** **4 DTaP** **3 Hep B** **1 Hib*** (on or after 1st birthday) **1 Varicella** **1 MMR** (on or after 1st birthday)

* One Hib dose must be given on or after the 1st birthday regardless of previous doses. Required only for children younger than 5 years old.

DTaP = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine

Hep B = hepatitis B vaccine

Varicella = chickenpox vaccine

Hib = Haemophilus influenzae, type B vaccine

MMR = measles, mumps, and rubella vaccine

Enroll. Get Care. Renew.

Free or Low Cost Health Coverage Exists for ALL Lower-Income California Families (options on page 2)

CALIFORNIA
Information for other states is different.

Renew Your Coverage in 2023-24!

IMPORTANT for 2023 and 2024:

CONTINUOUS MEDI-CAL COVERAGE PROTECTIONS END STARTING APRIL 2023.
Do you or a family member have Medi-Cal coverage? If so, you may need to take steps to keep it. You will need to renew your Medi-Cal at some point between April 2023 and May 2024. Annual renewals are usually due in the same month you first enrolled in Medi-Cal.

What to Do to Stay Covered:

- **Update your contact information.** Tell your county Medi-Cal office about any changes in your contact information (mailing address, phone number, email) so they can contact you with information about how to renew your coverage.
- **Check your mail.** When it is time to renew coverage, Medi-Cal will mail you a letter to let you know if you need to complete a renewal form or if your renewal can be completed automatically.
- **Complete your renewal form.** If you receive a renewal form, your coverage will not be renewed unless you complete it. Renewal forms will be sent in a **YELLOW ENVELOPE.** Fill out the form and answer any county follow up questions right away by phone, online, mail or in person to help avoid a gap in your coverage.

How to Renew your Medi-Cal Coverage and Report Changes:

- **Set up an account online.** Visit: ***https://benefitscal.com/*** OR
- **Contact your county Medi-Cal office.** To find your county Medi-Cal office, visit ***dhcs.ca.gov/COL*** or call ***(800) 541-5555.***

What if You No Longer Qualify for Medi-Cal Coverage?

If your family income increased above Medi-Cal eligibility levels (see income chart on second page), you may qualify for discounted premiums through Covered California. If so, when your Medi-Cal coverage ends, Covered California will send you information about your automatic enrollment and what you need to do to activate it. Your Covered California coverage would begin when:

- You pay your premium, OR
- If you have no premium, when you accept the coverage online or by phone.

Often when family income increases, your child(ren) may still qualify for Medi-Cal even if adult family members no longer qualify. Continue to fill out and submit renewal information to keep your child(ren)'s free Medi-Cal coverage even if you may be enrolled in Covered California.

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Need Help?
Scan this QR code for LOCAL HELP in your area.

OR GO TO:
www.allinforhealth.org

Enroll.

Ways to enroll in Medi-Cal and Covered California:

- ***1(800) 300-1506***
- ***www.coveredca.com***
- **In-person:** ***dhcs.ca.gov/COL***
- **Apply by mail:** Medi-Cal printable applications here: ***www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/SingleStreamApps.aspx***
- **Find Help in Your Community:** Scan the QR code below or go to: ***allinforhealth.org/HealthCoverageResources*** to locate help near you.

Get Care.

- Find a primary care doctor. Ask your health plan for help locating an available doctor near you.
- Schedule an annual checkup for you and your child(ren). Young children need frequent well-child visits within a year.
- Your health plan is required to help you make appointments and get interpretation services. Additionally, Medi-Cal is required to help you get free transportation to your appointments.
- Find a dentist. Visit ***SmileCalifornia.org*** to find a Medi-Cal dentist and a dental home near you.
- In Covered California, dental care is covered for children. Adults will need to purchase an additional dental plan.

Renew.

DHCS **Medi-Cal** must be renewed every year except for those listed below. It is important to ensure that Medi-Cal has your current address so that when it's time to renew your coverage, they can contact you. If you receive a renewal notice, be sure to act! Children in foster care and former foster care youth are not required to renew their coverage. Postpartum individuals also do not need to renew their coverage within 12 months postpartum

COVERED CALIFORNIA **Covered California** health plans must be renewed every year. Renewal information will be mailed at the end of the year, or you can contact Covered California directly.

Scan the QR code for information about when and how to renew!

Options for Health Coverage

Medi-Cal:

- Children and adults qualify for full-scope Medi-Cal benefits depending on their income. Children, pregnant and post-partum individuals have higher income eligibility levels than other adults (see chart below).
- Medi-Cal covers ALL COSTS for screenings, immunizations, checkups, specialists, mental health, vision, dental services, and all other medically necessary care.
- Medi-Cal enrollment is available year round.
- Most Medi-Cal enrollees must enroll in a Medi-Cal health plan that will manage their health care coverage. Each health plan is different and has their own list of healthcare providers. Learn more about health plans at: ***https://www.healthcareoptions.dhcs.ca.gov***
- Medi-Cal plans offer services using telehealth. Ask your provider about accessing care over video or phone.
- For more information about services covered under Medi-Cal for Kids & Teens, go to ***www.allinforhealth.org*** or click for the ***DHCS webpage***, flier for ***kids*** and ***teens*** and ***know your rights letter***.

Covered California:

- Covered California offers a selection of health plans. They help in comparing and choosing a health plan that works best for each person. To learn more, visit: ***CoveredCA.com***
- Many Californians may qualify for financial assistance via a Premium Tax Credit or reductions in what enrollees pay for their health care (known as cost-sharing reductions).
- Enroll during Open Enrollment or any time you experience a ***life-changing event***, like losing your job or having a baby. You have 60 days from the event to complete enrollment.

Immigrant Families

Expansion of Medi-Cal

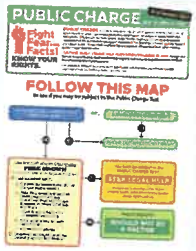
- Currently, every income-eligible child or person under the age of 26, every adult 50 years and older, DACA recipients, pregnant persons and recently pregnant persons are eligible for Medi-Cal health coverage and benefits **REGARDLESS OF IMMIGRATION STATUS.**
- Young people who are undocumented and turning 26 in 2023 will continue on Medi-Cal until 2024. By 2024, these individuals will be sent information about when and how to renew their Medi-Cal.
- In 2024, California is removing all barriers to Medi-Cal based on immigration status. Beginning on January 1, 2024, all California residents with qualifying incomes will be eligible for full Medi-Cal benefits regardless of their immigration status.

Covered California

- Those with immigration documentation can qualify for Covered California and its financial assistance. Some counties offer other health care options regardless of immigration status

Updated Public Charge Rule

- In December 2022, the federal government updated the public charge rule and made clear that using Medi-Cal is not considered for purposes of public charge (except in the case of long-term institutionalized care, also known as skilled nursing home care).
- Your child's enrollment in Medi-Cal and use of health care services will not impact your immigration status.
- While the public charge test may make you nervous, use this **Public Charge Roadmap** to better understand whether it applies to you or your family member.



Go to: ***allinforhealth.org/public-charge***

Financial Help. You or your family may qualify for free Medi-Cal or premium assistance under Covered California.*

SEE NOTE BELOW FOR INCOMES IN THIS RANGE	Covered California Premium Subsidies**								Tax credit continues beyond 400%	
	American Indian / Alaska Native (AI/AN) Zero Cost Sharing								AI/AN Limited Cost Sharing	
% FPL	**100%**	**138%**	**150%**	**200%**	**213%**	**250%**	**266%**	**300%**	**322%**	**400%**
Household Size	**If 2023 household income is at or less than**									
1	$13,590	$18,755	$20,385	$27,180	$28,947	$33,975	$36,150	$40,770	$43,760	$54,360
2	$18,310	$25,268	$27,465	$36,620	$39,001	$45,775	$48,705	$54,930	$58,959	$73,240
3	$23,030	$31,782	$34,545	$46,060	$49,054	$57,575	$61,260	$69,090	$74,157	$92,120
4	$27,750	$38,295	$41,625	$55,500	$59,108	$69,375	$73,815	$83,250	$89,355	$111,000
5	$32,470	$44,809	$48,705	$64,940	$69,162	$81,175	$86,371	$97,410	$104,554	$129,880
6	$37,190	$51,323	$55,785	$74,380	$79,215	$92,975	$98,926	$111,570	$119,752	$148,760
	Medi-Cal for Adults		Medi-Cal for Pregnant & Postpartum Individuals				Medi-Cal Access for Pregnant & Postpartum Individuals			
	Medi-Cal for Kids (0–18 Yrs.)							CCHIP***		

* For information on calculating income and household size visit: ***healthcare.gov/income-and-household-information***
** For Covered California, these 2023 income eligibility levels are effective at the beginning of the upcoming open enrollment period starting in November 1, 2023.
*** For San Francisco, San Mateo, and Santa Clara County residents only.
Note: Consumers after 138% FPL may qualify for a Covered California health plan with financial help including: federal premium tax credit, Zero Cost Sharing and Limited Cost Sharing AI/AN plans. Source: *www coveredca.com/pdfs/FPL-chart.pdf*

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OUR PARTNERS:
CALIFORNIA SCHOOL-BASED HEALTH ALLIANCE
MetroLA
para los niños for the children

FOR MORE INFORMATION GO TO: **www.allinforhealth.org**

RIALTO UNIFIED SCHOOL DISTRICT • HEALTH SERVICES • 815 S. WILLOW AVENUE, RIALTO, CA 92376 • TEL: (909) 820-8150

Possible Referrals: If you have a personal health care provider, please feel free to use them. ***We do not endorse any specific health care provider.***

Posibles referencias: Si tiene un proveedor de atención médica personal, no dude en utilizarlo. ***No respaldamos a ningún proveedor de atención médica específico.***

For additional information, please scan the QR codes provided. • Para obtener información adicional, escanee los códigos QR proporcionados.

DENTAL CARE

DENTI-CAL
(800) 322-6384

LOMA LINDA SCHOOL OF DENTISTRY
(Pediatric Dental Clinic)
Loma Linda (909) 558-4689

SAN BERNARDINO HEALTH CENTER
(For Dental Services)
606 E. Mill St., San Bernardino
(800) 722-4777

ONTARIO HEALTH CENTER
(For Dental Services)
150 E. Holt Blvd., Ontario
(909) 458-9447

INLAND FAMILY COMMUNITY HEALTH CENTER
(For Dental Services)
665 North 'D' St., San Bernardino
(909) 708-8168

GOLDEN WEST DENTISTRY
9922 Sierra Ave., Fontana
(909) 822-4800

B R DENTAL
(Next to Clinica Medica Familiar)
436 S. Riverside Ave., Rialto
(909) 874-5200

DR. DAVID A. NEWSHAM, DDS
1735 N. Riverside Ave., Rialto
(909) 820-9081

MEDICAL CARE

SAC HEALTH SYSTEM
815 S. Willow Ave., Rialto
To schedule an appointment
(909) 382-7100

SAN BERNARDINO HEALTH CENTER
(For Medical Services)
606 E. Mill St., San Bernardino
(800) 722-4777

ONTARIO HEALTH CENTER
(For Medical Services)
150 E. Holt Blvd., Ontario
(909) 458-9447

BLOOMINGTON COMMUNITY HEALTH CENTER
18601 Valley Blvd., Bloomington
(909) 546-7520

MOMMY AND ME MEDICAL GROUP
790 E. Foothill Blvd., Rialto
(909) 421-0493

ARROWHEAD FAMILY HEALTH CENTER
16888 Baseline Ave., Fontana
(855) 422-8029

INLAND FAMILY COMMUNITY HEALTH CENTER
(For Medical Services)
665 North 'D' St., San Bernardino
(909) 708-8158

MEDICAL CARE...*continued*

LASALLE MEDICAL ASSOCIATES
790 E. Foothill Blvd., Rialto
(909) 546-7135

UNICARE COMMUNITY HEALTH CENTER
17500 Foothill Blvd. #A-2, Fontana
(909) 428-0170

VISION EXAMS

NORTHPOINTE OPTOMETRIC CENTER
1850 N. Riverside Ave., Ste. 220
Rialto (909) 875-1144

RIALTO OPTOMETRIC CENTER
1850 N. Riverside Ave., Ste. 210
Rialto (909) 421-3030

COLTON OPTOMETRIC CENTER
190 W. H St., Ste. 105
Colton (909) 825-9044

COUNSELING SERVICES

MESA COUNSELING SERVICES
850 E. Foothill Blvd.
Rialto (909) 421-9358

SOUTH COAST COMMUNITY SERVICES
1461 E. Cooley Dr., Ste. 100, Colton
(877) 527-7227

COVERED CALIFORNIA
(800) 300-1506
www.coveredca.com

IEHP
(800) 720-4347
www.iehp.org

MEDI-CAL
(800) 410-8829
keepmedicalcoverage.org

BENEFITSCAL
(877) 410-8829
www.benefitscal.com

SAN BERNARDINO COUNTY - TRANSITIONAL ASSISTANCE DEPARTMENT
1175 W. Foothill Blvd., Rialto (877) 410-8829

Updated: 01/2024