2018-2019

Wheatland School District Child Development Program

**Once your packet is filled out, Please call to make an appointment.
530-633-3130 ext. 1115

Dear Parents:

Welcome to the Wheatland School District State Preschool Program. In order to expedite the registration process, **please complete all the forms in this packet prior to your appointment.**

**** Your child must be 3yrs or 4yrs old on or by September 1, 2018 to be age eligible.**

In addition, the following documentation is required to enroll your child:
Must bring to your scheduled appointment:

1. **Vaccination Records** – all immunizations must be up-to-date.

2. **Birth Certificate- for all children included in your family size**

3. **Income verification** – prior month's check stubs of all household income- *Subsidized Programs Only*

4. **Proof of Residency** – pay stub with address, bill with address

5. **Preschool Physical examination** done within **30 days of preschool sign-up** or within the past year. Form provided in packet. **Must complete Allergy information.**

6. **Attend Parent Orientation-**To be scheduled on the 1st day of class.
   This is mandatory and children will not attend school until this has been completed (if entering after the 1st day of class you will receive the Orientation Packet)

Parents must complete steps #6 and #7 to volunteer or attend field trips. Parent participation is mandatory for classes to participate in off campus activities. Class trips will be cancelled without parent support.

7. **Parent Fingerprint Live Scan**
   All families are to be Live Scanned through Wheatland School District. You can get the Live Scan form at 111 Main St. in the School District Office in Wheatland.

8. **Parent Tuberculosis skin test** current within the past 4 years, documentation required i.e. a shot record or note from facility. (Negative PPD)

9. **SB 792** now requires volunteers to provide proof of immunization against Pertussis (Tdap), Measles (MMR) and influenza. If you do not get the flu shot between August 1 and December 1 of each year, there is a waiver for you to sign.

Wheatland Child Development

Lone Tree and Wheatland Preschools

Part Day Preschool

Subsidized Preschool to eligible families.

Effective July 1, 2017 Income Ceilings have changed for Certification.

Find your family size on the left of the chart: if your income is at or less than the Subsidized amount your child qualifies for Free Preschool. If you fall under the 85% monthly income there are limited spaces available.

Family Size	Family Monthly Income 70% Subsidized (for Military Families: base income without BAH)	Family Yearly Income	Family Monthly Income 85% (accepted applicants are limited)	Family Yearly Income
1–2	$4,030	$48,361	$4,894	$58,724
3	$4,340	$52,076	$5,270	$63,235
4	$4,877	$58,524	$5,922	$71,065
5	$5,656	$67,888	$6,870	$82,436
6	$6,438	$77,252	$7,817	$93,806
7	$6,584	$79,008	$7,995	$95,938
8	$6,730	$80,763	$8,172	$98,070
9	$6,877	$82,519	$8,350	$100,202
10	$7,023	$84,275	$8,528	$102,334
11	$7,169	$86,031	$8,705	$104,466
12	$7,316	$87,786	$8,883	$106,598

*We also provide a Private Pay Option for families. Those spaces are limited and for 3-4-5 days a week.

WHEATLAND SCHOOL DISTRICT
CHILD DEVELOPMENT PROGRAM

PARENT AGREEMENT

I acknowledge that I, parent of _____ have received copies/information of the following documents.

____ Parents Rights Notification (LIC 995) / Personal Rights (LIC 813)

____ Appeal Procedures (Parent's Rights and Hearing Request)

____ Notice of Action and Appeal (funded program)

____ Parent handbook/calendar- given at orientation

The following program requirements have been explained to me:

____ Sign In/Sign Out/ Attendance Procedure
(Absences, Notification of absences)

____ Health and wellness (sick children, parent notification)

____ Birth Certificate

____ Current immunizations

____ 30 days to provide: Current physical

____ (2) Parent conference with written documentation

____ All family/child information is kept confidential

____ Site Emergency, Check phone numbers

____ Field trip/Volunteer requirements: Parent Live Scan, Negative T.B., **SB 792** now requires volunteers to provide proof of immunization against Pertussis (Tdap), Measles (MMR) and influenza. If you do not get the flu shot between August 1 and December 1 of each year, there is a waiver for you to sign.

____ I have been notified of the Notice of Action/Appeal procedure

____ Parent orientation will be held the 1st day of class- mandatory

I have read the above and agree to comply.

Parent's Signature_____ Interviewer_____

Date: _____ Date: _____

WHEATLAND SCHOOL DISTRICT
WHEATLAND CHILD DEVELOPMENT
COMMUNITY RESOURCES

Name of Parent /Guardian _____ Child's Name _____

(1) Please check items that are an area of concern or interest to you and your family.

- ☐ ALCOHOL & DRUG ABUSE
- ☐ ANIMALS
- ☐ CHILDREN'S ACTIVITIES
- ☐ CHILD CARE
- ☐ CHILD & FAMILY COUNSELING
- ☐ MISSING CHILDREN
- ☐ COMMUNITY INFORMATION
- ☐ COUNSELING/ MENTAL HEALTH
- ☐ DISABLED
- ☐ EMERGENCY/ SOCIAL SERVICES
- ☐ EMPLOYMENT/ TRAINING
- ☐ ENVIRONMENT/ RECYCLING
- ☐ FINANCIAL ASSISTANCE
- ☐ GOVERNMENT
- ☐ HOUSING
- ☐ LEGAL/CONSUMER INFORMATION
- ☐ MEDICAL-CLINICS
- ☐ MEDICAL-DISEASE INFORMATION
- ☐ MEDICAL-HOSPICE
- ☐ MEDICAL-SUPPORT GROUPS
- ☐ NATIVE AMERICANS
- ☐ PARENTING
- ☐ RECREATION
- ☐ SENIOR CITIZENS
- ☐ TRANSPORTATION
- ☐ UTILITIES
- ☐ VETERANS & MILITARY
- ☐ WOMEN'S SERVICES

(2) Please check items you would like to receive brochures & article hand-outs.

- ☐ AMERICAN RED CROSS
- ☐ CASA DE ESPERANZA
- ☐ CHILDREN'S HOME SOCIETY
- ☐ DEALING WITH CRISIS
- ☐ DEALING WITH STRESS
- ☐ DISCIPLINE TECHNIQUES
- ☐ HEAD LICE
- ☐ HOME ACTIVITIES WITH YOUR CHILD
- ☐ HOW TO GET ORGANIZED
- ☐ HOW TO HELP YOUR CHILD LEARN
- ☐ INFANT/CHILD GROWTH & DEVELOPMENT
- ☐ NUTRITION, DIET, EXERCISE, ETC.
- ☐ SIBLING/ PEER RELATIONSHIPS
- ☐ SUCCESSFUL SEPARATION
- ☐ YUBA COUNTY HEALTH DEPT.
- ☐ OTHER_____

(3) Please check areas below where you might want to assist our program.

- ☐ PARENT ADVISORY COMMITTEE
- ☐ SHARE A SPECIAL HOBBY OR TALENT
- ☐ TRANSLATE FOR NON-ENGLISH SPEAKING CHILD OR PARENT
- ☐ SHARING YOUR KNOWLEDGE OF CULTURAL BACKGROUND
- ☐ CENTER REPAIRS (ELECTRICAL, PLUMBING, CARPENTRY, PAINTING, YARDWORK)
- ☐ TYPING/NEWSLETTER
- ☐ FIELD TRIPS
- ☐ OTHER_____

SIGNATURE _____ DATE _____

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

AS THE PARENT, DOMESTIC PARTNER, 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, DOMESTIC PARTNER, OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Domestic Partner/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: 520 Cohasset Rd. Suite 170 Chico, CA 95926

   Licensing Office Telephone #: 530-895-5033

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/DOMESTIC PARTNER/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/DOMESTIC PARTNER/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 (1/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Domestic Partner/Authorized Representative Signature Required)

I, the parent/domestic partner/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.

Lone Tree Preschool/Wheatand Child Dev.
Name of Child Care Center

_____ _____
Signature (Parent/Domestic Partner/Authorized Representative) Date

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

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

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/DOMESTIC PARTNER,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 Practioner

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/DOMESTIC PARTNER'S NAME		DOES FATHER/DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/DOMESTIC PARTNER'S NAME		DOES MOTHER/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*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	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? AAAaaa

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/DOMESTIC PARTNER'S SIGNATURE	DATE

FOR OFFICE USE ONLY: ***Wheatland School District Emergency Information***

Teacher: _____ Grade: _____ School Site: LTPS WPS 2018-2019

All areas must be filled in completely, or indicate NA for not applicable. Do not fold. *Please use ball point pen.

Student's Name: _____ Date of Birth: ____/____/____ Sex: M F
(Last Name) (First Name) (Middle Name) MM DD YYYY

Street Address, City, and Zip: _____

Mailing Address (if different): _____ Primary Phone #: _____

Preferred Email Contact Address: _____

Residence – where is your child/family currently living? (federally mandated by NCLB) – **Please check appropriate box:**

☐ In a permanent residence (house, apartment, condo, mobile home) ☐ In a motel/hotel ☐ Temporarily unsheltered (car/campsite) ☐ In a shelter or transitional housing program
☐ Temporarily doubled-up (sharing housing with other families/individuals due to economic hardship or loss) ☐ Other (please specify) _____

Father's Name: _____ Employer: _____ Work #: _____

***(Military Only)** Branch of Service: _____ Rank: _____ Squadron: _____ Cell #: _____

Mother's Name: _____ Employer: _____ Work #: _____

***(Military Only)** Branch of Service: _____ Rank: _____ Squadron: _____ Cell #: _____

Do you or your spouse work on Federal Property? ☐ No ☐ Yes If yes, place of work: _____

Parent's highest level of education completed: ☐ Post Graduate (MA/MS/EdD/PhD) ☐ College graduate (BA/BS) ☐ Some College or Associate's Degree
☐ High School Graduate ☐ Not a High School Graduate

In the event you cannot be located, give the name of a daycare provider, neighbor, relative, or friend with whom the school may leave your child.
Relation: (3) Step-Mother (4) Step-Father (8) Friend (9) Neighbor (10) Daycare Provider (11) Relative (Please indicate which by placing the number in the relation portion)

Name: _____ Relation ( ) Phone: _____ Name: _____ Relation ( ) Phone: _____

Student Health and Medication Needs: _____

Food Allergies: _____

Family Information: Children of Family (List all children, including this child, in order of birth who reside in the home)

Name	Age	School	Name	Age	School

I ☐DO ☐DO NOT give permission for my child to have his/her name and picture used for: school and district publications, local newspapers, official school and district web pages.

PARENT SIGNATURE: _____ **DATE:** _____