

***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, 2016 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 1<sup>st</sup> day of class.  
*This is mandatory and children will not attend school until this has been completed( if entering after the 1<sup>st</sup> 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.

# Wheatland Child Development

## PART DAY PRESCHOOL

- 1) Subsidized preschool to eligible families
- 2) Private-pay 3-4-5 days to families that exceed income guidelines

We provide two convenient locations:

- 1) Beale AFB at Lone Tree School
- 2) Wheatland Elementary School

Call: (530) 633-3130 ext.1110

nsteenberga@wheatland.k12.ca.us

Preschool Income Table: Find your family size on the far left, and if your income is at or less than the two amounts listed then your child qualifies for subsidized preschool program.

Family Size (adults and children at home)	Family Monthly Income (base income, without BAH )	15% Flex over income ( accepted applicants are limited)
1-2	\$3,283	\$3775.45
3	\$3,518	\$4045.70
4	\$3,908	\$4494.20
5	\$4,534	\$5214.10
6	\$5,159	\$5932.85
7	\$5,276	\$6067.40
8	\$5,394	\$6203.10
9	\$5,511	\$6337.65
10	\$5,628	\$6472.20
11	\$5,745	\$6606.75

# 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 8 : 30  
(NAME OF CHILD CARE CENTER/SCHOOL)  
 a.m./p.m. to 11:30 a.m./p.m. , 5 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 <small>(DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)</small>	/ /	/ /	/ /	/ /	/ /
MMR <small>(MEASLES, MUMPS, AND RUBELLA)</small>	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS <small>(REQUIRED FOR CHILD CARE ONLY (HAEMOPHILUS B))</small>	/ /	/ /	/ /	/ /	/ /
HEPATITIS B	/ /	/ /	/ /	/ /	/ /
VARICELLA <small>(CHICKENPOX)</small>	/ /	/ /	/ /	/ /	/ /

**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

# GUIDE TO IMMUNIZATIONS REQUIRED FOR CHILD CARE OR PRESCHOOL



Requirements by Age at Entry and Later (Follow-up is required at every age checkpoint after entry.)

Vaccine	2-3 Months	4-5 Months	6-14 Months	15-17 Months	18 Months-5 Years
Polio (OPV or IPV)	1 dose	2 doses	2 doses	3 doses	3 doses
Diphtheria, Tetanus, and Pertussis (DTaP or DTP)	1 dose	2 doses	3 doses	3 doses	4 doses
Measles, Mumps, and Rubella (MMR)				1 dose on or after the 1st birthday	1 dose on or after the 1st birthday
Hib	1 dose	2 doses	2 doses	1 dose on or after the 1st birthday	1 dose on or after the 1st birthday (only required for children less than 4 years, 6 months)
Hepatitis B (Hep B or HBV)	1 dose	2 doses	2 doses	2 doses	3 doses
Varicella (chickenpox, VAR or VZV)					1 dose

## INSTRUCTIONS:

To enter a child care center, day nursery, nursery school, family day care home, or development center, children must have received immunizations required by California law.

- Parents must submit their child's immunization record as proof.
- Copy the date of each vaccine onto the California School Immunization Record (Blue Card, CDPH-286).
- Determine whether children meet requirements above.

## ADMIT A CHILD UNCONDITIONALLY WHO:

- Is 18 months and older and has all immunizations required for their age, or
- Submits a personal beliefs exemption (PBE) filed at a prior California child-care facility for missing shot(s) and immunization records with dates for all required shots not exempted. The PBE must have been filed before January 1, 2016 and is only valid until entry to transitional kindergarten/kindergarten. For complete details, see ShotsforSchool.org.
- Submits a licensed physician's written statement of a permanent medical exemption for missing shot(s) and immunization records with dates for all required shots not exempted.

## ADMIT A CHILD CONDITIONALLY IF THE CHILD:

- Is under age 18 months, has received all immunizations required for age, but will have more required at next age checkpoint.
- Is missing a dose(s) in a series, but the next dose is not due yet (This means the child has received at least one dose in a series and the deadline for the next dose has not passed.) The child may not be admitted if the deadline has passed or the child has not yet received the 1<sup>st</sup> dose.
- Has a temporary medical exemption to certain vaccine(s) and has submitted an immunization record for vaccines not exempted. The statement must indicate which immunization(s) must be postponed and when the child can be immunized.

## WHEN MISSING DOSES CAN BE GIVEN:

Missing Dose	Earliest Date After Previous Dose	Deadline After Previous Dose
Polio #2	6 weeks	10 weeks
Polio #3	6 weeks	12 months
DTP/DTaP #2, #3	4 weeks	8 weeks
DTP or DTaP #4	6 months	12 months
Hib #2	2 months	3 months
Hep B #2	1 month	2 months
Hep B #3 (under age 18 months)	2 months after 2nd dose and at least 4 months after 1st dose	12 months after 2nd dose and at least 4 months after 1st dose
Hep B #3 (age 18 months and older)	2 months after 2nd dose and at least 4 months after 1st dose	6 months after 2nd dose and at least 4 months after 1st dose

## DO NOT ADMIT A CHILD WHO:

Does not fit one of the prior categories. Refer parents to their physician with a written notice indicating which doses are needed.

## FOLLOW-UP IS REQUIRED AFTER ADMISSION:

- At every age checkpoint above until all doses are received.
- If child was behind schedule and admitted **conditionally**.
- If child has a temporary medical exemption.

Maintain a list of unimmunized children (exempted or admitted conditionally), so they can be excluded quickly if an outbreak occurs. Notify parents of the deadline for missing doses. Review records every 30 days until all required doses are received.

Questions? Visit [ShotsForSchool.org](http://ShotsForSchool.org) or contact your local health department ([bit.do/immunization](http://bit.do/immunization)).

## MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School/Agency Name	2. Site Name	3. Site Telephone Number	
4. Name of Participant		5. Age or Date of Birth	
6. Name of Parent or Guardian		7. Telephone Number	
8. Check One: <input type="checkbox"/> Participant has a disability or a medical condition and <i>requires</i> a special meal or accommodation. (Refer to definitions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. <b>A licensed physician must sign this form.</b>  <input type="checkbox"/> Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. <b>A licensed physician, physician's assistant, or nurse practitioner must sign this form.</b>			
9. Disability or medical condition requiring a special meal or accommodation:			
10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:			
11. Diet prescription and/or accommodation: <i>(Please describe in detail to ensure proper implementation-use extra pages as needed)</i>			
12. Indicate texture: <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed			
13. Foods to be omitted and substitutions: <i>(Please list specific foods to be omitted and suggested substitutions. You may attach a sheet with additional information as needed)</i>			
<b>A. Foods To Be Omitted</b>		<b>B. Suggested Substitutions</b>	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
14. Adaptive Equipment:			
15. Signature of Preparer*	16. Printed Name	17. Telephone Number	18. Date
19. Signature of Medical Authority*	20. Printed Name	21. Telephone Number	22. Date

\* Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form.

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

## INSTRUCTIONS

1. **School/Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served (e.g., school site, child care center, etc.).
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
5. **Age of Participant:** Print the age of the participant. For infants, please use date of birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Telephone Number:** Print the telephone number of parent or guardian.
8. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
9. **Disability or Medical Condition Requiring a Special Meal or Accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.).
10. **If Participant has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition affects disability (e.g., Allergy to peanuts causes a life-threatening reaction).
11. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician, or describe diet modification requested for a nondisabling condition (e.g., All foods must be either in liquid or pureed form. Participant cannot consume any solid foods).
12. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
13. **A. Foods to Be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).  
**B. Suggested Substitutions:** List specific foods to include in the diet (e.g., calcium-fortified juice).
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).
15. **Signature of Preparer:** Signature of person completing form.
16. **Printed Name:** Print name of person completing form.
17. **Telephone Number:** Telephone number of person completing form.
18. **Date:** Date preparer signed form.
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
20. **Printed Name:** Print name of medical authority.
21. **Telephone Number:** Telephone number of medical authority.
22. **Date:** Date medical authority signed form.

### Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

**A person with a disability** is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

**Physical or mental impairment** means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

**Major life activities** include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

**Major bodily functions** have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.

**"Has a record of such an impairment"** means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.

# Your Child at 3 Years



Child's Name \_\_\_\_\_

Child's Age \_\_\_\_\_

Today's Date \_\_\_\_\_

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 3rd birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

## What Most Children Do at this Age:

### Social/Emotional

- Copies adults and friends
- Shows affection for friends without prompting
- Takes turns in games
- Shows concern for a crying friend
- Understands the idea of "mine" and "his" or "hers"
- Shows a wide range of emotions
- Separates easily from mom and dad
- May get upset with major changes in routine
- Dresses and undresses self

### Language/Communication

- Follows instructions with 2 or 3 steps
- Can name most familiar things
- Understands words like "in," "on," and "under"
- Says first name, age, and sex
- Names a friend
- Says words like "I," "me," "we," and "you" and some plurals (cars, dogs, cats)
- Talks well enough for strangers to understand most of the time
- Carries on a conversation using 2 to 3 sentences

### Cognitive (learning, thinking, problem-solving)

- Can work toys with buttons, levers, and moving parts
- Plays make-believe with dolls, animals, and people
- Does puzzles with 3 or 4 pieces
- Understands what "two" means
- Copies a circle with pencil or crayon
- Turns book pages one at a time
- Builds towers of more than 6 blocks
- Screws and unscrews jar lids or turns door handle

### Movement/Physical Development

- Climbs well
- Runs easily
- Pedals a tricycle (3-wheel bike)
- Walks up and down stairs, one foot on each step

## Act Early by Talking to Your Child's Doctor if Your Child:

- Falls down a lot or has trouble with stairs
- Drools or has very unclear speech
- Can't work simple toys (such as peg boards, simple puzzles, turning handle)
- Doesn't speak in sentences
- Doesn't understand simple instructions
- Doesn't play pretend or make-believe
- Doesn't want to play with other children or with toys
- Doesn't make eye contact
- Loses skills he once had

**Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to [www.cdc.gov/concerned](http://www.cdc.gov/concerned) or call 1-800-CDC-INFO.**

Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2008, Elk Grove Village, IL: American Academy of Pediatrics. This milestone checklist is not a substitute for a standardized, validated developmental screening tool.

[www.cdc.gov/actearly](http://www.cdc.gov/actearly)

1-800-CDC-INFO



Learn the Signs. Act Early.

# Your Child at 4 Years



Child's Name \_\_\_\_\_

Child's Age \_\_\_\_\_

Today's Date \_\_\_\_\_

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 4th birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

## What Most Children Do at this Age:

### Social/Emotional

- Enjoys doing new things
- Plays "Mom" and "Dad"
- Is more and more creative with make-believe play
- Would rather play with other children than by himself
- Cooperates with other children
- Often can't tell what's real and what's make-believe
- Talks about what she likes and what she is interested in

### Language/Communication

- Knows some basic rules of grammar, such as correctly using "he" and "she"
- Sings a song or says a poem from memory such as the "Itsy Bitsy Spider" or the "Wheels on the Bus"
- Tells stories
- Can say first and last name

### Cognitive (learning, thinking, problem-solving)

- Names some colors and some numbers
- Understands the idea of counting
- Starts to understand time
- Remembers parts of a story
- Understands the idea of "same" and "different"
- Draws a person with 2 to 4 body parts
- Uses scissors
- Starts to copy some capital letters
- Plays board or card games
- Tells you what he thinks is going to happen next in a book

### Movement/Physical Development

- Hops and stands on one foot up to 2 seconds
- Catches a bounced ball most of the time
- Pours, cuts with supervision, and mashes own food

## Act Early by Talking to Your Child's Doctor if Your Child:

- Can't jump in place
- Has trouble scribbling
- Shows no interest in interactive games or make-believe
- Ignores other children or doesn't respond to people outside the family
- Resists dressing, sleeping, and using the toilet
- Can't retell a favorite story
- Doesn't follow 3-part commands
- Doesn't understand "same" and "different"
- Doesn't use "me" and "you" correctly
- Speaks unclearly
- Loses skills he once had

**Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to [www.cdc.gov/concerned](http://www.cdc.gov/concerned) or call 1-800-CDC-INFO.**

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[www.cdc.gov/actearly](http://www.cdc.gov/actearly)

1-800-CDC-INFO



Learn the Signs. Act Early.

**WHEATLAND SCHOOL DISTRICT  
PRESCHOOL PROGRAM**

**ENROLLMENT CONDITIONS**

**Preschool/ Child Care is dependent on you!**

**Enrollment is conditional, never permanent!**

*Preschool/ Child Care is dependent on:*

1. Following rules and regulations.

*Most common reasons for losing preschool/child care services:*

1. Failure to sign your child in/out according to procedures **3 times**.
  - a. Must use first and last name for signature – NO INITIALS.
  - b. Must indicate accurate time when signing in/out.
  - c. Must fill in reason for absence and sign with first and last name.
2. Failure to observe contract hours.
3. Preschool/child care placement is inappropriate for the child.
4. Failure to report new telephone number or home address.

**I have read and understand the above.**

\_\_\_\_\_  
Parent/ Guardian Signature

\_\_\_\_\_  
Date

# 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- given at orientation  
(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 requirements: parent live scan, parent T.B. requirement
- \_\_\_\_\_ I have been notified of the Notice of Action/Appeal procedure
- \_\_\_\_\_ Parent orientations- mandatory

I have read the above and agree to comply.

Parent's Signature \_\_\_\_\_ Interviewer \_\_\_\_\_

Date: \_\_\_\_\_ Date: \_\_\_\_\_

**IDENTIFICATION AND EMERGENCY INFORMATION**  
**CHILD CARE CENTERS/FAMILY CHILD CARE HOMES**  
**To Be Completed by Parent, Domestic Partner or Authorized Representative**

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					BIRTHDATE
FATHER'S/GUARDIAN'S/DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

**ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY**

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

**PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY**

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

CALL EMERGENCY HOSPITAL     OTHER    EXPLAIN: \_\_\_\_\_

**NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY**

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT, DOMESTIC PARTNER OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN/DOMESTIC PARTNER OR AUTHORIZED REPRESENTATIVE	DATE
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**TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE**

DATE OF ADMISSION	DATE LEFT
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# 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.

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

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

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

# WHEATLAND SCHOOL DISTRICT WHEATLAND CHILD DEVELOPMENT

## FRAUD POLICY STATEMENT

California Department of Education requires Wheatland School District Child Development Program to inform families receiving State/Federal child care assistance that if child care assistance is obtained through fraudulent or incomplete information, Wheatland School District Child Development Program shall pursue recovery of funds due for child care services.

Fraudulent, false, or misleading information provided regarding your employment/student training status, income or eligibility relating to medical incapacity, will be grounds for termination and will be cause for the Wheatland School District Child Development Program to recover funds.

1. Failure to report information regarding wages, including commissions, overtime, bonuses, SSI/SSP, child support, or other income received necessary to document eligibility and parent fees will result in termination from the program and is cause for the Wheatland School District Child Development Program to recover the funds for your child care services. All income must be reported.
2. Documentation supplied to Wheatland School District Child Development Program regarding all adults in the home must be complete and true. Fraudulent, false, or misleading documentation regarding training programs, schools, medical incapacitation, employment and/or income is cause for termination and recovery of funds.
3. If your services are terminated for any of the above reasons, you may file an appeal and if you lose the appeal, you will have to repay a money that the Wheatland School District Child Development Program, paid during the time your appeal was being heard. Eligibility for further child care assistance will be denied for at least 12 months.

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Wheatland School District Child Development Program will attempt to recover funds from both the state funded and the private funded program by developing a repayment plan with the parent. If the parent does not respond to the repayment plan or misses the payments as stated in the repayment plan, the school where the child attends, or will attend, will be notified to withhold the report card and/or records for the child until the debt is paid. This action is in accordance with Wheatland School District Policy#5125 and Ed Code 48904.3. If payment is not received, a claim will be filed with Small Claims Court. If payment is not made, the claim will be referred to the District Attorney's office. (Legal Reference: 45 Code of Federal Regulations (CFR) Parts 98 & 99, Child Care and Development Block Grant, Section 98.6, and California Education Code, Section 8263 et al.)

I have read the above information and understand that failure to provide information regarding eligibility and/or providing false, fraudulent and misleading information will result in termination from the Wheatland School District Child Development Program, assistance program and that I will have to pay back to Wheatland School District Child Development Program, any money paid out by the Wheatland School District Child Development Program for my child care.

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Parent

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), domestic partner(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/DOMESTIC PARTNER/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

Community Care Licensing

ADDRESS

520 Cohasset Rd. Suite 170

CITY

Chico

ZIP CODE

95926

AREA CODE/TELEPHONE NUMBER

530-895-5033

DETACH HERE

**TO: PARENT/DOMESTIC PARTNER/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)

Lone Tree Preschool/Wheatland Child Development

(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/DOMESTIC PARTNER/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/DOMESTIC PARTNER/GUARDIAN)

(DATE)

## 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](http://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](http://www.meganslaw.ca.gov)*

**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
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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**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?*	IF YES, AT WHAT STAGE?*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*		

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

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/DOMESTIC PARTNER'S SIGNATURE	DATE
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Teacher: \_\_\_\_\_

Grade: \_\_\_\_\_

School Site: LTPS WPS

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

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

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
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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:** \_\_\_\_\_

