2022/2023

Wheatland School District Child Development Program

**Once your packet is filled out, Please call to make an appointment.
530-633-3130 ext. 1110

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 December 1, 2022 to be age eligible.

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

- ☐ **Vaccination Records** – all immunizations must be up-to-date.
- ☐ **Birth Certificate- for all children included in your family size**
- ☐ **Income verification** – prior month's check stubs of all household income- *Subsidized Programs Only*
- ☐ **Proof of Residency** – pay stub with address, bill with address
- ☐ **Preschool Physical examination** done within **30 days of preschool sign-up** or within the past year. Form provided in packet. **Must complete Allergy information.**

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 the steps below 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.

- ☐ **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.
- ☐ **Parent Tuberculosis skin test** current within the past 4 years, documentation required i.e. a shot record or note from facility.
- ☐ **SB 792** now requires volunteers to provide proof of immunization against Pertussis (Tdap), Measles (MMR) and influenza (or waiver).
- ☐ **COVID Vaccine** at this time you will be required to show proof of vaccine or will need to be tested before volunteering. Subject to change.

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.

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.

_____

Parent 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
(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
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. Excessive Absences.
3. Failure to observe contract hours.
4. Preschool/child care placement is inappropriate for the child.
5. Failure to report new telephone number or home address.
6. Failure to pay Preschool fees.

I have read and understand the above.

_____ _____

Parent/ Guardian Signature Date

Wheatland
SCHOOL DISTRICT
Learning For All

AUTHORIZATION FOR EMPLOYER TO RELEASE INFORMATION

(Please read the following statements, sign below, and return to the WSD Preschool Office.)

I, _____, hereby authorize my employer, _____, to release any and all information relating to my employment income with them to Wheatland School District Preschool. I understand that any information released by my employer will be held in strictest confidence, that it will be viewed only by those involved in the qualification for Subsidized Preschool decision, and that anyone else not so involved will have the right to see the information.

_____ _____

Signature of Employee Date

_____

Employee's Name - Printed

111 Main Street
Wheatland CA, 95692

Phone: (530) 633-3130
Fax: (530) 633-4807
www.wheatlandsd.com

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	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Chico	95926	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)	(PRINT THE ADDRESS OF THE FACILITY)
Lone Tree Preschool/Wheatland Child Development	123 Beale HWY, BAFB/711 West Olive, Wheatland

(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

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

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
( )	( )

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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* 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? 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

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

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

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

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)

_____ (NAME OF CHILD), born _____ (BIRTH DATE) is being studied for readiness to enter _____ (NAME OF CHILD CARE CENTER/SCHOOL). This Child Care Center/School provides a program which extends from _____ : _____ 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

Student: _____

WHEATLAND SCHOOL DISTRICT PRESCHOOL
COMMUNITY RESOURCES

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

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

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

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

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

		Follow-up
	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:	

☐ **Do not need any services at this time.**

_____ _____

Parent Signature Date

*Follow up (30 Days from the start of school or 30-days from enrollment for new students).

_____ _____

Parent Signature Teacher Signature