Campbell
UNION SCHOOL DISTRICT

Dear Parent,

Thank you for your interest in Campbell Union School District's State Preschool Programs. CUSD is a proud participate of the Santa Clara County Subsidized Childcare Pilot Program. In Santa Clara County, this means that a family of four with a maximum monthly income of $6,719 and annual income of $80,623 now qualifies for subsidy. To determine if you qualify for our free or low cost preschool program, please see the chart below.

Family Size	Family Monthly Income	Family Yearly Income
1-2	$5,343	$64,120
3	$5,802	$69,620
4	$6,719	$80,623
5	$7,794	$93,522
6	$8,869	$106,422
7	$9,070	$108,841
8	$9,272	$111,259
9	$9,473	$113,678
10	$9,675	$116,096
11	$9,876	$118,516
12	$10,078	$120,934

We provide full-day and part-day preschool services, free of charge or low cost, to eligible families who live in Santa Clara County. Our programs are located at 6 of our school district's elementary sites for children ages 3 months to 5 years old. Please fill out the application completely and if you need help, you can call us Monday through Friday from 7:45am to 4:00pm.

Please note that as part of the enrollment process, you will have an enrollment appointment with a staff member.

Student's Name:_____ **Classroom /Site**:_____

Enrollment Date/ Time:_____ **Start Date:**_____

Orientation Date/ Time:_____

To determine your eligibility, please provide copies of the following documents and complete this packet in its entirety and return to one of our enrollment offices. Our enrollment offices are located at:

Rosemary Family Learning Center, 401 West Hamilton Ave, Campbell, CA 95008

Sherman Oaks Preschool, 1800 Fruitdale Ave, San Jose, CA 92128

Eligibility Document Checklist (Copies only; these will not be returned)

☐ **Income Verification** – The documents need to show your income **for the past 12 months**. All parent or guardian income needs to be submitted. This includes: (any combination of the following to complete 12 months)

- **Latest Income Tax Return (1040) or W2 with 1 recent month of check stubs or Pay Stubs for 12 Months**
- **Notice of Action** (if receiving cash aid from CalWORKs, not food stamps)
- **Proof of SSI - Supplemental Security Income** (if applicable)
- **Unemployment Income**
- **Worker's Compensation**
- **Child Support**
- **Disability Income**
- **Completed "Employer Income Verification"** (This is a form showing hours worked and pay rate)

☐ **Birth Certificate(s)** (for the child and all siblings under 18)

☐ **Proof of Address** (i.e., a phone bill, water bill, etc.)

☐ **Immunization Records**

☐ **Physician's Report with TB Assessment or TB Test Results**

☐ **Proof of Legal Custody** (if the child is in foster care)

☐ **Homeless Verification** (if applicable and if available)

☐ **Current IEP (Individualized Education Program) or IFSP (Individualized Family Service Plan)** (if applicable)

☐ **Full Time Employment or School enrollment/Training Verification** (if you would like full day services)

☐ **Completed State Preschool Services Application**

Campbell
UNION SCHOOL DISTRICT

CUSD State Preschool Services Application

Child (Applicant)

First Name	Last Name	Middle	Gender	Birth Date
			__Male __ Female	/ /
Home Address		City/Zip	Birth City	Birth Country

Is the child in foster care?	**Ethnicity**	**Race**	
__Yes ___ No	__Hispanic/Latino	__Asian	___Pacific Islander/Hawaiian
	___Non/Hispanic/Non-Latino	__White	___American Indian/Alaskan
		___Black/African American	___More than 1 race
		___Pacific Islander/Hawaiian	___Other:_____

Does the child have a current IEP or IFSP? __Yes __No If yes, please complete the Disabilities section of this application

Family Information

Primary Language Spoken at Home ___English ___Spanish ___Vietnamese ___Other:_____

Which dominant language does your child speak? ___English ___Spanish ___Vietnamese ___Other:_____

Name of Person(s) Having Legal Custody of the Child	Parents/Guardians In the Home	Primary Email Address
	___ One Parent ___ Two Parents	

Parent/Guardian 1 Name	Birth Date	Relationship To Child

Lives with the child	**Marital Status**	**Primary Phone Number**	**Employment Status**
___Yes ___No	__Married __Divorced __Widowed __Separated	( ) -	__Employed __Seeking Employment
	__Single		__Unemployed __Retired
			__Disabled ___ Student
			__Incapacitated From ____to_____

Campbell
UNION SCHOOL DISTRICT

Parent/Guardian 2 Name		Birth Date	Relationship To Child
Lives with the child ___Yes ___No	**Marital Status** __Married __Divorced __Widowed __Separated __Single	**Primary Phone Number** ( ) -	**Employment Status** __Employed __Seeking Employment __Unemployed __Retired __Disabled ___ Student __Incapacitated From ____to_____

List all other family members living in the household for whom you are responsible for the care and welfare-NOT LISTED ABOVE: (Under the age of 18)

First Name	Last Name	Date of Birth	Is this person related to the child's guardian(s)?	Is this person supported by guardian(s) income?
		/ /	__Yes __No	__Yes __No
		/ /	__Yes __No	__Yes __No
		/ /	__Yes __No	__Yes __No
		/ /	__Yes __No	__Yes __No
		/ /	__Yes __No	__Yes __No
		/ /	__Yes __No	__Yes __No
Total number of people living in the household (including you) for whom you provide financial support				

Family Residency

Temporarily in one of the following due to inadequate housing, financial hardship, or loss of housing.

Family Living Situation (Check all that apply)

__Shelter Name:_____

__Motel/Hotel Name:_____

__Transitional Housing Name:_____

__Single Room Occupancy

__Car, Trailer, or Campsite

__Rented Garage

__Rented Trailer, Motor Home, or Private Property

__With another adult (Not the parent/legal guardian)

__Another family's house/apartment

__None of the options apply

__Other, Explain:_____

_____

Campbell
UNION SCHOOL DISTRICT

Eligibility

Parent/Guardian 1			Parent/Guardian 2	
Name	Has Income __Yes __No		Name	Has Income __Yes __No
Check all that apply Do you receive: Monthly Amount __TANF/CalWORKS $_____ __SSI $_____ __Child Support $_____ __Other sources of income $_____			Check all that apply Do you receive: Monthly Amount __TANF/CalWORKS $_____ __SSI $_____ __Child Support $_____ __Other sources of income $_____	
Employment Information			Employment Information	
Employer Name	Employer Phone ( ) -		Employer Name	Employer Phone ( ) -
Employer Name	Employer Phone ( ) -		Employer Name	Employer Phone ( ) -
Pay Periods: __Weekly __Every 2 Weeks __Twice Per Month __Monthly Gross Income $_____ Per _____			Pay Periods: __Weekly __Every 2 Weeks __Twice Per Month __Monthly Gross Income $_____ Per _____	
School/Training Information			School/Training Information	
Are you in school or training? __Yes __No			Are you in school or training? __Yes __No	
School Name	School Phone		School Name	School Phone
Semester/Quarter Dates / / to / /	Units Enrolled		Semester/Quarter Dates / / to / /	Units Enrolled

Disabilities	
Does your child have an Individualized Education Plan (IEP) with your local school district of residence or County Office of Education? If yes, please attach a copy of the most recent IEP	___Yes ___No
Does your child have an Individual Family Service Plan (IFSP) with an early intervention program, regional center, County Office of Education, or School District? If yes, please attach a copy of the most recent IFSP.	___Yes ___No
Additional information about your child's disability or other developmental concerns. Please explain if checked "yes" above.	_____ _____

Parent/Guardian Signature_____

Date_____

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

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

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

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

DATE OF ADMISSION	DATE LEFT

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*	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?

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

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

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

CUSD Preschools
_____ 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
( )	( )

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
2580 N. First St. #300

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
San Jose	95131	408-324-2148

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)
CUSD Preschools	401 W. Hamilton Ave Campbell, Ca 95008

(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: 2580 N. First St #300, San Jose, Ca 95131

   Licensing Office Telephone #: 408-324-2148

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.

CUSD Preschools
_____
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

IMPORTANT INFORMATION FOR PARENTS

CAREGIVER BACKGROUND CHECK PROCESS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

The California Department of Social Services works to protect the safety of children in child care by licensing child care centers and family child care homes. Our highest priority is to be sure that children are in safe and healthy child care settings. California law requires a background check for any adult who owns, lives in, or works in a licensed child care home or center. Each of these adults must submit fingerprints so that a background check can be done to see if they have any history of crime. If we find that a person has been convicted of a crime other than a minor traffic violation or a marijuana-related offense covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7, he/she cannot work or live in the licensed child care home or center unless approved by the Department. This approval is called an exemption.

A person convicted of a crime such as murder, rape, torture, kidnapping, crimes of sexual violence or molestation against children **cannot by law be given an exemption that would allow them to own, live in or work in** a licensed child care home or center. If the crime was a felony or a serious misdemeanor, the person must leave the facility while the request is being reviewed. If the crime is less serious, he/she may be allowed to remain in the licensed child care home or center while the exemption request is being reviewed.

How the Exemption Request is Reviewed

We request information from police departments, the FBI and the courts about the person's record. We consider the type of crime, how many crimes there were, how long ago the crime happened and whether the person has been honest in what they told us.

The person who needs the exemption must provide information about:

- The crime
- What they have done to change their life and obey the law
- Whether they are working, going to school, or receiving training
- Whether they have successfully completed a counseling or rehabilitation program

The person also gives us reference letters from people who aren't related to them who know about their history and their life now.

We look at all these things very carefully in making our decision on exemptions. By law this information cannot be shared with the public.

How to Obtain More Information

As a parent or authorized representative of a child in licensed child care, you have the right to ask the licensed child care home or center whether anyone working or living there has an exemption. If you request this information, and there is a person with an exemption, the child care home or center must tell you the person's name and how he or she is involved with the home or center and give you the name, address, and telephone number of the local licensing office. You may also get the person's name by contacting the local licensing office. You may find the address and phone number on our website. The website address is **http://ccld.ca.gov/contact.htm.**

Campbell
UNION SCHOOL DISTRICT

Santa Clara County Pilot Program Agreement (07/01/18)

The Santa Clara County Child Subsidy Project (the Pilot) was designed to meet the needs and goals of our local community. The goal of the Pilot is to increase stability of care for families by allowing extended certification periods and allows families to be accepted or remain in the program with higher gross monthly income.

I. DURATION OF ELIGIBILITY AND NEED *[This amends CD 9600 Section V(7)]*

Once services have been approved by means of a Notice of Action (NOA), duration of certification are as followed, but not limited to:

- Families Seeking Employment, 12 months from certification.
- All other qualifications may be 24 months from certification.
- Duration may be affected by space limitation for children transitioning from one program to another (i.e. toddler to preschool, preschool to school-age).

II. NOTIFICATION REQUIREMENTS

Families shall, **within thirty (30) calendar days** notify the enrollment office:

- If the family's gross monthly (pre-tax) income exceeds the maximum allowable, outlined below.

Family Size	1 or 2	3	4	5	6	7	8	9	10	11	12
Monthly Income	$5,343	$5,802	$6,719	$7,794	$8,869	$9,070	$9,272	$9,473	$9,675	$9,876	$10,078

III. FAMILY'S RIGHT TO VOLUNTARILY REPORT CHANGES *[Title 5 section 18084.2]*

Families have a right to voluntarily report changes if:

- It reduces the Family Fee.
- It increases the family's services.
- It extends the period of eligibility.

IV. PARENT SIGNATURE

I declare, under penalty of perjury, that I will adhere to the requirements outlined above and that all information provided is true and accurate. I understand that I have not been officially approved for services until I receive my Notice of Action (NOA).

_____ _____

Parent/Guardian Signature Date

Dear Parent / Guardian,

Your child(s) early childhood program is participating in a quality improvement initiative known as QUALITY MATTERS…a STRONG START for kids. This initiative is designed to support your child's program in providing high quality early learning experiences.

We are dedicated to helping your child care provider improve their day-to-day practice and continue to grow professionally, therefore we must periodically collect information about children and staff in order to provide the best support to your child care provider. Attached is a consent form that we are asking you to sign, so that your child's information can be shared with QUALITY MATTERS staff/administrators. This consent form will let you know what information is being collected and your rights as parent/guardian.

If you have any questions, please ask your child care provider.

PARENT CONSENT

Authorization for use or disclosure of student information to and from early childhood programs

Completion of this document authorizes the disclosure and/or use of personally identifiable student information between your child's school, CUSD Preschools and FIRST 5 Santa Clara County and Santa Clara County Office of Education, as set forth below, consistent with California and Federal laws concerning the privacy of such information. If you consent to disclosure of information as described herein, please fill out, sign and return this form to your child care provider.

Student(s)

_____ _____ __/__/_____

First Name Middle Initial Last Name Date of Birth

I, the undersigned, hereby authorize the above named Student's preschool, CUSD Preschools, FIRST 5 Santa Clara County and Santa Clara County Office of Education to exchange information regarding the named student(s) above. The information is exchanged for program evaluation purposes and for programming and service planning. The information will be exchanged between your child's preschool, FIRST 5 Santa Clara County and Santa Clara County Office of Education for the purpose of providing safe, appropriate, and high quality education settings and quality preschool services and programs.

Requested information shall be limited to the following: Your child's name, ethnicity, date of birth, primary language, results from Screening Tools: Ages and Stages Questionnaire 3, Ages and Stages Questionnaire: Social Emotional, Desired Results Developmental Profile (2015), Special needs (IFSP/IEP) if applicable.

Duration: This authorization shall become effective immediately and shall remain in effect until the child's end of enrollment or terminated by parent/guardian through written notice.

Restrictions on Re-Disclosure: California law prohibits the requestor from making further or additional disclosure of private information to another third party unless the requestor obtains another authorization from you, or the disclosure is specifically required or permitted by law.

Your Rights: You have the following rights with respect to this authorization, and affirm you understand them in signing this release form. You may withdraw this authorization at any time by submitting written note signed by you or your representative and delivered to the agency/persons listed above. You have the right to receive a copy of this authorization.

Approval: _____

Printed Name Signature Date

_____ _____

Relationship to Student Area Code and Telephone Number

CAMPBELL UNION SCHOOL DISTRICT
STATEMENT OF GOOD HEALTH

Dear Parents/Family Members of C.U.S.D. Preschool Students:

Please read and complete this form for each family member who will be partnering/volunteering in the classroom this year.

****

All licensed childcare programs in the state of California are governed by the California Department of Social Services, Community Care Licensing Division. The rules that cover childcare centers are called Title 22 Regulations. Within the regulations there is a section that details personnel requirements which states:

Reg. 101216 PERSONNEL REQUIREMENTS

All personnel, including the licensee, administrator and **volunteers**, shall be in good health and shall be physically and mentally capable of performing assigned tasks.

The good physical health of each **volunteer** who works in the center shall be verified by: A statement signed by each volunteer affirming that he/she is in good health.

****

STATEMENT OF GOOD HEALTH

I understand that in order to ensure the health and safety of children within the Campbell Union School District Preschool Program, and to meet Title 22 regulations, that all individuals spending time within the classroom must have on file a statement of good Health.

Therefore, by signing below, I am affirming that I have read the above information and am in good health.

I, (print name)_____do affirm that I am in good health. I am volunteering in the preschool classroom as a:

☐ Family Member_____
*Name of Preschool Child and **Relationship** to child*

☐ Work –Study Student/Student Teacher

☐ Other Volunteer

_____ _____
Signature Date

FOR OFFICE USE ONLY: Received Date: _____ Initial _____

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)

CUSD Preschools
_____ . 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

RISK FACTORS FOR TB IN CHILDREN:

* Have a family member or contacts with a history of confirmed or suspected TB.
* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
* Live in out-of-home placements.
* Have, or are suspected to have, HIV infection.
* Live with an adult with HIV seropositivity.
* Live with an adult who has been incarcerated in the last five years.
* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
* Have abnormalities on chest X-ray suggestive of TB.
* Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.