TwinRivers UNIFIED SCHOOL DISTRICT

Click Here to Start Over

# Enroll Now!! Preschool 2020 – 2021

**PLEASE MAKE SURE YOU ARE OPENING AND FILLING OUT THIS APPLICATION IN ADOBE READER. BEFORE COMPLETING, PLEASE READ THESE DIRECTIONS: *CLICK HERE***

| In order to enroll your child, please provide the following documentation: | |
|---|---|
| ☐ | **Birth Certificate Verification for the enrolling student.** |
| ☐ | **Birth Certificate Verification for all brothers and sisters under the age of 18 still living at home.** |
| ☐ | **Current Proof of Income dated within 30 days of your appointment date.**<br>If you get paid:<br>- Weekly: last four consecutive paystubs.<br>- Every two weeks: last two consecutive paystubs (pay cycle is usually 14 days).<br>- Biweekly: last two consecutive paystubs (pay cycle usually 15 days or longer – pay received 1st & 15th or 5th & 20th).<br>- Monthly: pay is received once per month.<br>- Income can be wages, unemployment, cash aid, housing support, public assistance, disability/unemployment, workers compensation, spousal support, child support, survivor benefits, retirement, benefits, dividends/interest, rental income, foster care grant, financial assistance for child, veterans pension, annuity, inheritance, housing/auto included in pay, student loan living expenses, or insurance settlements |
| ☐ | **Current Proof of Address dated within 30 days of your appointment date.** One of the following:<br>- (PG&E, Telephone-landline, Utility or Rental Agreement with current rent receipt). |
| ☐ | **Immunization Record for the enrolling student.** The California School Immunization Law requires that children be up-to-date with their shots. |
| ☐ | **TB Risk Assessment** |
| ☐ | **Health Evaluation/Physical** -given within a year of entry into school. Early Head Start Physical dated at 24 or 30 months (or scheduled appointment verification)<br>- If Health Evaluation is not available and the child's immunizations are up to date, parent must sign a 30 day waiver. Child may be dis-enrolled if we do not receive the physical within 30 days. |
| ☐ | **Court Documents (if applicable)** |
| ☐ | **IEP/IFSP (if applicable)** |
| ☐ | **Full Day ONLY - Employment Verification or Training Verification** |
| ☐ | **Head Start ONLY – Dental exam** dated within one year of enrollment (or scheduled appointment verification) |
| ☐ | **Head Start ONLY – Medical Insurance Card** |
| ☐ | **Head Start ONLY – WIC card (if applicable)** |

**Enrollment priority will be given to families through the following:**

- Age
- Require preschool/children's center attendance due to special family circumstance (CPS referral, Foster child, In Transition, etc.)
- Family Income and/or Need (State Income Matrix)
- Homelessness
- IEP Participation

TwinRivers
UNIFIED SCHOOL DISTRICT

# Fact Sheet

Twin Rivers Unified School District offers low or no cost programs to children ages 0 - entry to kindergarten. To ensure children of highest need are served, verification of income will be requested of all families. Below are facts about the enrollment, priority and child's placement.

**Please Initial Boxes Below**

## CSPP Part Day Preschool, CSPP Full Day Preschool & CCTR Infant/Toddler Care

- Registration may begin up to 120 days before the start of school.
- Preschool children must be 3 years old on or before 12/1/20 (children born between 12/1/16 - 12/1/17).
- Priority enrollment placement is based on income and other guidelines determined by the California Department of Education
- Families who are over income may be placed after eligible families have been placed.
- Dual Immersion is available. Space is limited. (Part Day Preschool only)

## Head Start Preschool & Early Head Start Infant/Toddler Care

- Income guidelines are determined by the Federal Office of Head Start.
- Priority given to students with special needs, experiencing homelessness, in the foster care system, & income eligible students.
- Over income waivers are available on case by case basis and must be approved by SETA.

## All Preschool & Infant/Toddler Programs

- The official school site placement for your child will be given to the family during your enrollment appointment.
- Please make sure we have all your current contact information.
- If we are unable to reach you after multiple attempts, your spot may become unavailable.
- **Completing the application does not guarantee enrollment at the school/class of your choice.**

## Transitional Kindergarten (TK)

- I understand that a child with a birth date that falls between 9/2/15 to 12/1/16 is eligible to be enrolled in Transitional Kindergarten for the following school year. If you wish to enroll your child in a TK classroom, STOP. You will need to fill out a different application. *Please click here.*

Parent/Guardian Signature

Date

# Early Childhood Programs

## State Full-Day Programs

- Program Hours: 7:00am - 5:00pm
- Families receive an amount of certified hours based on need.
- Employment Verification needed
- Pacific Infant/Toddler Center: 0-3 years old (limited space)

- ❖ Babcock Elementary
- ❖ Kohler Elementary
- ❖ Madison Elementary
- ❖ Noralto Elementary
- ❖ Northwood Elementary
- ❖ Pacific Infant/Toddler Center
- ❖ Smythe Elementary
- ❖ Strauch Elementary
- ❖ Vineland Preschool
- ❖ Woodridge Elementary

## State Part-Day Programs

- AM program hours: 8:00 am - 11:00am or 8:30am - 11:30am (depending on site)
- PM program hours: 12:00pm - 3:00pm or 12:30pm - 3:30pm (depending on site)

- ❖ Castori Elementary
- ❖ Del Paso Heights Elementary
- ❖ Fairbanks Elementary
- ❖ Garden Valley Elementary
- ❖ Hagginwood Elementary
- ❖ Joyce Elementary
- ❖ Kohler Elementary
- ❖ Noralto Elementary
- ❖ Northwood Preschool
- ❖ Orchard Elementary
- ❖ Sierra View Elementary
- ❖ Smythe Elementary
- ❖ Strauch Elementary
- ❖ Woodlake Elementary
- ❖ Woodridge Elementary

## Head Start Programs

- Program Hours: 8:00am - 2:30pm Mon-Thurs & ONE Friday in the month
- Early Head Start (24-36 Months): 8:00am - 2:30pm Mon - Friday

- ❖ Morey Avenue Center
- ❖ Oakdale Elementary
- ❖ Rio Linda Children s Center
- ❖ Village Elementary

ALL FIELDS MUST BE COMPLETED

TwinRivers UNIFIED SCHOOL DISTRICT

# ENROLLMENT INFORMATION/ EMERGENCY CARD

OFFICE USE ONLY
School of Enrollment: _____
Start Date: _____ Stu ID: _____
Teacher: _____ Class: _____

Has your student ever attended school in Twin Rivers before? ☐ Yes ☐ No

**PLEASE PRINT – STUDENT'S LEGAL NAME**

| FIRST Name: | MIDDLE Name: | LAST Name: | Suffix (i.e. JR) |
|---|---|---|---|
| | | | |

Name Preferred: _____

☐ Male ☐ Female ☐ Non Binary Birth Date: ____ ____ ____ (Month / Day / Year) Age: _____

STUDENT'S BIRTHPLACE: City: _____ State: _____ Country: _____

_____ _____ _____ _____ _____
Residence Street Address (Verification Required) Apt# City State Zip

**PROGRAM/SCHOOL PREFERENCES**

Which program are you applying for? ☐ State Part Day ☐ State Full Day ☐ Head Start

School of choice: 1st: _____ 2nd: _____

* **Please find a list of the preschool locations that are available on the previous page (page 3)**

**PARENT/LEGAL GUARDIAN INFORMATION: *(Whom the student lives with)***

PRIMARY CONTACT:
☐ Father ☐ Mother ☐ Step-Father ☐ Step-Mother ☐ Guardian ☐ Foster ☐ Caregiver ☐ Other

Name: _____ Date of Birth: _____ Phone: (_____) _____

Address: _____ Occupation: _____

Email: _____

☐ Father ☐ Mother ☐ Step-Father ☐ Step-Mother ☐ Guardian ☐ Foster ☐ Caregiver ☐ Other

Name: _____ Date of Birth: _____ Phone: (_____) _____

Address: _____ Occupation: _____

If biological parent not in home: ☐ Father ☐ Mother Phone: (_____) _____

Name: _____ Address: _____

**Are any of the above Parents/Legal Guardians on Active Military Duty or serving on full-time National Guard duty ☐ Yes ☐ No**
**Is the above (checked) person(s) the student s LEGAL Guardian ☐ Yes ☐ No If NO, please complete a Caregiver Affidavit .**
**Is there a custody court order or restraining orders regarding this student: ☐ Yes ☐ No. If YES, please provide copies.**

**LIST OF CHILDREN IN THE HOME:**

| Name | Year of Birth | Name | Year of Birth |
|---|---|---|---|
| 1. _____ | _____ | 2. _____ | _____ |
| 3. _____ | _____ | 4. _____ | _____ |

Student Last Name:

First Name:

TRUSD ID:

Please continue on Reverse Side ➔

Student Last Name:

First Name:

TRUSD ID:

## ETHNICITY AND RACE: Please answer both questions

*CA Gov't Code Section 8310.5 requires we collect this data.*

1. What is your child's ethnicity? *(Mark only one)* ◯ HISPANIC or LATINO (2) ◯ Not Hispanic or Latino

2. What is your child's race? *(Mark one or more)*

☐ WHITE (1): Persons having origins in any of the original peoples of Europe, North Africa or the Middle East
☐ AFRICAN AMERICAN / BLACK (3)
☐ NATIVE AMERICAN / ALASKA NATIVE (5): Persons having origins in any of the original people of North, Central, or South America - including Mexico

**ASIAN (4):**

☐ Chinese (4.1) ☐ Laotian (4.5) ☐ Other Asian (4.9)
☐ Japanese (4.2) ☐ Cambodian (4.6) ☐ Filipino (6)
☐ Korean (4.3) ☐ Asian Indian (4.7)
☐ Vietnamese (4.4) ☐ Hmong (4.8)

**NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER (7):**

☐ Hawaiian (7.1) ☐ Other Pacific Islander (7.5)
☐ Guamanian (7.2)
☐ Samoan (7.3)
☐ Tahitian (7.4)

## SPECIAL EDUCATION:

Does your child receive Special Education services? ◯ Yes ◯ No Does your child have an active 504 Plan? ◯ Yes ◯ No

Please Explain: _____

## PARENT EDUCATION:

Check the education level of the most educated parent/guardian that the child lives with.

◯ Graduate School/post training (10) ◯ Some college (includes AA) (12) ◯ Not a high school graduate (14)
◯ College Graduate (11) ◯ High School Graduate (13) ◯ Decline to state/unknown (15)

## EMERGENCY CONTACTS

**If my child is ill, has an emergency , or is suspended and I cannot be reached, please call and release my child to:**

Name: _____ Relationship: _____ Phone: (____) _____

Name: _____ Relationship: _____ Phone: (____) _____

Name: _____ Relationship: _____ Phone: (____) _____

## HEALTH CONCERNS

☐ Please take my child to the nearest emergency aid station, by ambulance if necessary, for treatment. I authorize treatment of my child by a licensed physician or surgeon and agree to bear all costs incurred.

☐ No, I do not choose the above statement and desire the following action in the event of an emergency:

_____

**Please check ALL that apply to your child:**

☐ Asthma ☐ Seizures ☐ Migraines ☐ Diabetes ☐ Hyperactive (ADHD) ☐ Heart Condition

☐ Allergic to Insect bites/stings:_____ Allergies: _____

☐ Other_____ Epi Pen give to school? ☐ Yes ☐ No Are any of the above life threatening? ☐ Yes ☐ No

If your child has a physical condition which limits participation, please describe: _____

**List medication prescribed:** _____ **Need to be taken during school hours:** ☐ **Yes** ☐ **No**

**Dosage:** _____ **for (diagnosis)** _____

**List medication prescribed:** _____ **Need to be taken during school hours:** ☐ **Yes** ☐ **No**

**Dosage:** _____ **for (diagnosis)** _____

## VISION / HEARING - Please check any that apply to your child

☐ Requires preferential seating ☐ Wears glasses ☐ Glasses worn at all times ☐ Wears contacts ☐ Contacts worn at all times
☐ Has a hearing problem ☐ Has tubes in ears ☐ Uses hearing aid

- Signature of Parent/Guardian: _____ Date: _____

CALIFORNIA IMMUNIZATION REQUIREMENTS FOR

# PRE-KINDERGARTEN

(any private or public child care center, day nursery, nursery school, family day care home, or development center)

**Doses required by age when admitted and at each age checkpoint after entry[1]:**

| AGE WHEN ADMITTED | TOTAL NUMBER OF DOSES REQUIRED OF EACH IMMUNIZATION[2,3] | | | | |
|---|---|---|---|---|---|
| 2 through 3 months | 1 Polio | 1 DTaP | 1 Hep B | 1 Hib | |
| 4 through 5 months | 2 Polio | 2 DTaP | 2 Hep B | 2 Hib | |
| 6 through 14 months | 2 Polio | 3 DTaP | 2 Hep B | 2 Hib | |
| 15 through 17 months | 3 Polio | 3 DTaP | 2 Hep B | | 1 Varicella |
| | | On or after the 1st birthday: | | 1 Hib[4] | 1 MMR |
| 18 months through 5 years | 3 Polio | 4 DTaP | 3 Hep B | | 1 Varicella |
| | | On or after the 1st birthday: | | 1 Hib[4] | 1 MMR |

1. A pupil's parent or guardian must provide documentation of a pupil's proof of immunization to the governing authority no more than 30 days after a pupil becomes subject to any additional requirement(s) based on age, as indicated in the table above (Table A).
2. Combination vaccines (e.g., MMRV) meet the requirements for individual component vaccines. Doses of DTP count towards the DTaP requirement.
3. Any vaccine administered four or fewer days prior to the minimum required age is valid.
4. One Hib dose must be given on or after the first birthday regardless of previous doses. Required only for children who have not reached the age of five years.

DTaP = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine
Hib = Haemophilus influenzae, type B vaccine
Hep B = hepatitis B vaccine
MMR = measles, mumps, and rubella vaccine
Varicella = chickenpox vaccine

## INSTRUCTIONS:

California pre-kindergarten (child care or preschool) facilities are required to check immunizations for all new admissions and at each age checkpoint.

**UNCONDITIONALLY ADMIT** a pupil age 18 months or older whose parent or guardian has provided documentation of any of the following for each immunization required for the pupil's age as defined in table above:

- Receipt of immunization.
- A permanent medical exemption in accordance with 17 CCR section 6051.
- A personal beliefs exemption (filed prior to 2016) in accordance with Health and Safety Code section 120335.

# CONDITIONAL ADMISSION SCHEDULE FOR PRE-KINDERGARTEN

Before admission a child must obtain the first dose of each required vaccine and any subsequent doses that are due because the period of time allowed before exclusion has elapsed.

| DOSE | EARLIEST DOSE MAY BE GIVEN | EXCLUDE IF NOT GIVEN BY |
|---|---|---|
| **Polio #2** | 4 weeks after 1st dose | 8 weeks after 1st dose |
| **Polio #3** | 4 weeks after 2nd dose | 12 months after 2nd dose |
| **DTaP #2, #3** | 4 weeks after previous dose | 8 weeks after previous dose |
| **DTaP #4** | 6 months after 3rd dose | 12 months after 3rd dose |
| **Hib #2** | 4 weeks after 1st dose | 8 weeks after 1st dose |
| **Hep B #2** | 4 weeks after 1st dose | 8 weeks after 1st dose |
| **Hep B #3** | 8 weeks after 2nd dose and at least 4 months after 1st dose | 12 months after 2nd dose |

**CONDITIONALLY ADMIT** any pupil who lacks documentation for unconditional admission if the pupil:

- has commenced receiving doses of all the vaccines required for the pupil's age (table on page 1) and is not currently due for any doses at the time of admission (as determined by intervals listed in Conditional Admission Schedule, column entitled "EXCLUDE IF NOT GIVEN BY"), or
- is younger than 18 months and has received all the immunizations required for the pupil's age (table on page 1) but will require additional vaccine doses at an older age (i.e., at next age checkpoint), or
- has a temporary medical exemption from some or all required immunizations (17 CCR section 6050).

**Continued attendance** after conditional admission is contingent upon documentation of receipt of the remaining required immunizations. The pre-kindergarten facility shall notify the pupil's parent or guardian of the date by which the pupil must complete all remaining doses.

**Questions?**

**See the California Immunization Handbook at ShotsForSchool.org**

# TB RISK ASSESSMENT

Child Name: _____ Date of Birth: ____/____/____

School: _____

| Please answer the following: | | |
|---|---|---|
| **Has the child come in close contact with a person infected with TB?** | ○ **Yes** | ○ **No** |
| **Is the child infected with or at risk of infection of HIV?** | ○ **Yes** | ○ **No** |
| **Is the child foreign born, a refugee or a migrant?** | ○ **Yes** | ○ **No** |
| **Has the child had contact with an incarcerated person or a person who has been incarcerated within the last 5 years?** | ○ **Yes** | ○ **No** |
| **Has the child been exposed to any of the following individuals: HIV infected, homeless individuals, residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, migrant farm workers and/or those who have recently visited outside of the U.S.?** | ○ **Yes** | ○ **No** |
| **Does the child have a medical condition which suppresses the immune system?** | ○ **Yes** | ○ **No** |
| **Does the child live in a community in which it has been established that a high risk exists for TB?** | ○ **Yes** | ○ **No** |
| **Has the child traveled to any foreign countries since the last medical visit?** | ○ **Yes** | ○ **No** |

**Attention Staff:**

If a parent answers "Yes" to any of the above questions, for **state preschool** this child must be routed to SOP Health/Nutrition Services upon entry into the classroom; for **Head Start** child must be referred to doctor for TB test.
(***Note***: This process **DOES NOT** prohibit the child from entering the classroom.)

1st Year Parent/Guardian signature Date

1st Year Staff signature Date

2nd Year Parent/Guardian signature Date

2nd Year Staff signature Date

(Rev.02/20)

TwinRivers
UNIFIED SCHOOL DISTRICT

## 30 Days Agreement for Medical Assessment

Student Full Name _____

Parent/Guardian Name_____

Office Use Only

Enrollment Date_____ Due Date_____

*Community Care Licensing - Title 22, Division 12, Chapter 1, Section 101220:* ***Prior to, or within 30 calendar days following the enrollment of a child, the licensee shall obtain a written medical assessment of the child….Such assessment shall be performed by, or under the supervision of a licensed physician, and shall not be more than one year old when obtained.***

I understand that I have 30 calendar days from the enrollment date of my child to provide a written medical assessment signed by a physician for my child. I also understand that my child may be dis-enrolled from the Early Learning/Pre-kindergarten program if I do not provide the medical assessment.

_____ _____

Parent/Guardian Signature Date

# HOME LANGUAGE SURVEY

English

Date_____ School_____ Student Number_____

Birthdate_____/_____/_____ Country of Birth_____

Foreign Born: If foreign born, date student first entered US _____ Date student first enrolled in US school_____

Last grade completed in home country_____ Date of enrollment to CA school_____

---

The California Education Code Section 52164.1 **requires** that schools determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students. If a language other than English is spoken in the home, the District is required to do further assessment of your son/daughter.

Your cooperation in helping us meet this important requirement is requested. Please answer the follow questions. Thank you for your help.

NAME OF STUDENT:_____
FIRST MIDDLE LAST

GRADE:_____ AGE:_____ SEX:_____

Which language did your son or daughter learn when he or she first began to speak?_____

What language does your son or daughter most frequently use at home?_____

What language do you use most frequently to speak to your son or daughter?_____

Name the language most often spoken by the adults at home._____

Parent telephone number_____ _____
SIGNATURE OF PARENT OR GUARDIAN

**********

**Speaking and Understanding English**

Is your child able to speak English? ☐ Yes ☐ No

Is your child able to understand English? ☐ Yes ☐ No

What percentage of time does your child understand English? ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

**Early Childhood Education**

# Family Partnership Profile

Date: _____ School: _____

Child's Name: _____ Child's Date of Birth: ___/___/___

Parent/Guardian Name: _____ Relationship to child: _____

Parent/Guardian Name: _____ Relationship to child: _____

Number of parents living in the home: ☐ Two Parents ☐ One Parent

Are you currently working? ☐Yes ☐No Going to school? ☐Yes ☐No

Is your spouse/partner currently working? ☐Yes ☐No Going to school? ☐Yes ☐No

| What type of housing does your family currently live in? (check all that apply) | | | | | |
|---|---|---|---|---|---|
| ☐ Own | ☐ Rent | ☐ Section 8/Subsidized | ☐ House | ☐ Apartment | ☐ Duplex |
| ☐ Motel | ☐ Mobile Home | ☐ With Family/Friends | ☐ Shelter | ☐ Homeless | ☐ Other |

| Does your family receive any of the following types of service? (check all that apply) | | | |
|---|---|---|---|
| ☐ Preexisting Plan with other Agency | ☐ TANF/CAL Works | ☐ Alta Regional Center | ☐ WEAVE |
| ☐ Unemployment | ☐ Child Support | ☐ Family Preservation | ☐ Probation |
| ☐ Energy Assistance | ☐ Food Stamps | ☐ Social Security (SSI/SSA) | ☐ WIC |
| ☐ Section 8/Housing Assistance | ☐ Child Action | ☐ Other | |

What information or services would you be interested in receiving? Check all that apply. **E=Emergency I=Information**

| Emergency/Crisis | ☐ No need | |
|---|---|---|
| **Categories** | **E** | **I** |
| Food | ☐ | ☐ |
| Clothes | ☐ | ☐ |
| Housing | ☐ | ☐ |
| Utilities | ☐ | ☐ |
| Mental Health Counseling (severe depression, Stress, Family) | ☐ | ☐ |
| Child Abuse Prevention | ☐ | ☐ |
| Domestic Violence | ☐ | ☐ |
| Nutrition | ☐ | ☐ |
| RT, car-seat | ☐ | ☐ |

| Education/ Employment | ☐ No need | |
|---|---|---|
| **Categories** | **E** | **I** |
| Job Search | ☐ | ☐ |
| College | ☐ | ☐ |
| GED/HS | ☐ | ☐ |
| Computer | ☐ | ☐ |
| Vocational | ☐ | ☐ |
| Adult Basic Ed (Read/Write) | ☐ | ☐ |
| ESL | ☐ | ☐ |
| Budget | ☐ | ☐ |
| Cooking | ☐ | ☐ |
| Pre-K (home activities) | ☐ | ☐ |
| Library | ☐ | ☐ |

| Family Issues | ☐ No need | |
|---|---|---|
| **Categories** | **E** | **I** |
| Special Needs | ☐ | ☐ |
| Parenting (child dev, discipline, classes) | ☐ | ☐ |
| Health (Dental, Med) | ☐ | ☐ |
| Child Support | ☐ | ☐ |
| Counseling (social skills) | ☐ | ☐ |
| Incarceration | ☐ | ☐ |
| Male Involvement | ☐ | ☐ |
| Child Care | ☐ | ☐ |

Parent Signature: _____ Staff Initial: _____ Date Received: _____

Followed-up by: _____ Date: _____

**2020-21**

# Twin Rivers Housing Questionnaire

## Child Welfare & Attendance Office

## Student Services

***Your child may be eligible for additional educational services through Title 1, Part A and/or federal McKinney-Vento assistance. Eligibility can be determined by completing this questionnaire.***

| Student(s) Name | Male/Female | School | Grade | DOB | Start Date |
|---|---|---|---|---|---|
| | ☐ M ☐ F | | | | |
| | ☐ M ☐ F | | | | |
| | ☐ M ☐ F | | | | |
| | ☐ M ☐ F | | | | |
| | ☐ M ☐ F | | | | |
| | ☐ M ☐ F | | | | |

****All other children in the home not enrolled in school: Yes◯ (Please list) No◯**

| Child's Name | Date of Birth | Child's Name | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**1. Where is your child/family currently staying?** ***(Check one box only)*** *This information will be used to determine if your child qualifies for any additional assistance under the "Every Student Succeeds Act (ESSA) of 2016".*

- ☐ **A.** Own home or Renting and *on the lease* of a single family residence
- ☐ **B.** With more than one family in a house or apartment *due to economic hardship*
- ☐ **C.** In an emergency shelter or transitional housing program:
  ***Name of Program/Address:*** _____
- ☐ **D.** In a motel:
  ***Name of Motel/Address/Room #:*** _____
- ☐ **E.** Unsheltered (ie: car, camp site, outside, or a structure not intended for sleeping)
- ☐ **F.** Housing that is *inadequate* (ie: no electricity, running water, etc.)
- ☐ **G.** In a foster care placement or group home

**If B-F are checked, does your student/s need school supplies? Yes◯ No◯**

**2. The student(s) live(s) with:**

☐ Parent(s) ☐ A friend(s) ☐ A qualified relative
☐ An adult who is not the legal guardian ☐ Unaccompanied Youth

Parent/Guardian Signature: _____ Date: _____

**Current address where staying**:

_____

(***Must complete to qualify & receive services***)

**Telephone/Message Numbers**_____

***School Staff: Be sure all information is complete then SCAN this form to Carol Seward (carol.seward@twinriversusd.org) in the Child Welfare and Attendance Office***

Revised 12/2019

# Declaration of Residency

**To be completed by parent/guardian wishing to enroll child/children**

Name of Parent/Guardian: _____

Present Address: _____ Apt. #: _____ Phone: (  ) _____

City: _____ Zip Code: _____

I, _____, do solemnly swear (or affirm) that my child,

_____, and I reside at above mentioned address. Proof of residency is provided.

_____ _____

**Signature of Parent/Guardian** **Date**

## 3rd Party Affidavit for Sharing a Residence

(when living with another family)

I, _____, do solemnly swear (or affirm) that I am the primary resident of

_____ and that the above

family is currently residing in my home. Proof of residency is provided.

_____ _____

Signature of Resident Date

**PLEASE NOTE: "Perjury is punishable by imprisonment in the state prison for two, three, or four years." -PC Section 126**

**For School Use Only**

Residency Approved: ◯ _____ Residency Denied: ◯ _____

Method of verification: _____

_____ _____

**Signature of School Official** **Date**

# CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

IF NOT APPLICABLE ENTER N/A

| 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 |
|---|---|

Site: _____

Student: _____

## HEAD START / EARLY HEAD START / STATE PRESCHOOL

## ***Adult Code of Conduct***

### Policy:

It is Twin Rivers Unified School District's (TRUSD) Head Start/Early Head Start/State Preschool policy to ensure the business of the program is conducted in accordance with the highest ethical standards. The underlying principles of these standards are based on courtesy, moral standards, and the law. These principles ensure the continued success and growth of the program and services provided by TRUSD Head Start/Early Head Start/State Preschool. TRUSD's goal is to ensure that all Head Start/Early Head Start/State Preschool functions and classrooms are safe, both physically and emotionally, for children and adults. All TRUSD Head Start/Early Head Start/State Preschool classrooms instill three basic principles for children:

1. **Be Kind**
2. **Be Safe**
3. **Be Clean**

These principles equally extend to each adult (parent, guardian, family member, volunteer and staff) involved in the child's TRUSD Head Start/Early Head Start/State Preschool experience.

### Code of Conduct:

All staff, parents, guardians, family members, and volunteers must abide by the following established code of conduct. Principles of the code include, but are not limited to:

1. Respect and promote the unique identities of all children, families, and adults, and refrain from stereotyping on the basis of gender, race, ethnicity, culture, religion, disability or sexual orientation;

2. Follow program confidentiality policies concerning information about children, families, and other staff;

3. Provide safe environments for all children and ensure they are supervised by qualified staff at all times and not left alone while in the care of TRUSD Head Start/Early Head Start/State Preschool;

4. Use positive methods of child guidance. The following is prohibited: engaging in corporal punishment, emotional abuse, physical abuse or humiliation; using methods of discipline that involve isolation without adult supervision, the use of food as punishment or regard; and/or the denial of basic needs.

### Expectations:

The ***Parent/Volunteer Code of Conduct*** will include, but not be limited to, the following items:

- ***Parents or family members will address misbehaviors of their own children attending a Head Start/Early Head Start/State Preschool function or classroom in a positive manner.*** No physical or verbal punishment or belittling of children is allowed at a Head Start/Early Head Start/State Preschool function or in a classroom; this includes, but is not limited to striking your child in any way or cursing at your child.

- ***Parents or family members will direct all concerns regarding children at a Head Start/Early Head Start/State Preschool function or in a classroom to Head Start staff immediately.*** It is never appropriate for a parent or family member to discipline another child at a school function or in a classroom. It is not the intent of this standard to stop a parent or family member from helping a child who is in immediate danger, but to use common sense in a situation where a child may be at risk of being harmed or who may be harming others.

- ***Parents or family members will treat Head Start/Early Head Start/State Preschool staff members with respect, and follow agency policy regarding disagreement or concerns.*** It is never appropriate for a parent or family member to threaten, disrespect or confront a staff member in any way, or speak of Incidents that occurred at the center In front of others. If the parent or family member has an issue or concern regarding Incidents that occurred at school, they should contact the Director/Principal to resolve the Issue. Confidentiality will be maintained in all discussions involving children, parents, volunteers, and staff members.

- ***If a parent or family member has a disagreement or problem with another parent or family member at a Head Start/Early Head Start/State Preschool function or in a classroom that problem will be addressed with respect following program protocol.*** It is never appropriate for a parent or family member to disrespect or threaten another parent or family member at a school function or in a classroom. This also includes inappropriate or negative remarks, body language, visible animosity or hostile eye contact.

- ***When in the presence of children at a Head Start/Early Head Start/State Preschool function or classroom, parents or family members will use language appropriate for young children to hear.*** Cursing or swearing or use of inappropriate language is not allowed. Speaking negatively in front of your child, other children, parents or community members about staff or enrolled families is inappropriate and impacts the emotional well-being of all involved and negatively impacts the program.

- ***To ensure the safety and health of all children, all safety rules, Including but not limited to, will be enforced:***
    a. According to California law, all children will be placed in appropriate vehicle restraints at all times.
    b. Children will not be left unattended in a vehicle.
    c. Parents who appear to be impaired by an illegal substance, drugs or alcohol will not be permitted to pick up their children. Should staff suspect an adult is impaired, he/she will assist the adult to find alternative transportation. Staff will contact 911 immediately if the adult insists on picking up their child while under the influence of alcohol.

- If a situation occurs that places staff, children, parents or family members at harm, TRUSD Head Start/Early Head Start/State Preschool ***reserves the right to ask the parent/family member to leave the school function/event, center, classroom or In some cases, the program. In the event that the parent/family member refuses to leave, the appropriate authorities may be called. TRUSD Head Start/Early Head Start/State Preschool may also reevaluate the enrollment status of a family to participate in the program.***

I have read, understand, and pledge to abide by the TRUSD Head Start/Early Head Start/State Preschool ***Adult Code of Conduct.***

Parent/Guardian Signature _____ Date _____

Staff Signature _____ Date _____

Distribution: White: Student's File Yellow: Parent

## CHILD CARE CENTER – NOTIFICATION OF RIGHTS AND PERSONAL RIGHTS

**PARENTS' RIGHTS LIC 995 (9/08) –** 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: ***CA Dept of Social Services Community Care Licensing**
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**

---

**ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS**

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.

Parent/Guardian_____
Initial

**PERSONAL RIGHTS LIC 613A (8/08)**, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Center. 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 mee his/her needs.
   (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, three, 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:**

***CA Dept. of Social Services**
**Community Care Licensing**
2525 Natomas Park Dr. Ste. 250 MS 19-29
Sacramento, CA 95833
(916) 263-5744

**TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:** Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgement:

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

_____ _____
School Name Date

_____ _____
Print the Name of the Child Signature (Parent/Guardian/Authorized Representative) and Title

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

Fill out this form if you are applying for
**Full Day State Preschool Only**

## AUTHORIZATION TO RELEASE EMPLOYMENT INFORMATION

**Completed by Parent/Guardian 1**

Student's Name_____

_____ _____
Employee Name Company Phone Number

_____ _____
Company Business Name Company Contact Name

_____ _____ _____
Company Address City Zip Code

_____
Company Business Hours

**********

*Twin Rivers Unified School District/Early Learning Department has permission to contact my employer to verify my employment & income information.*
*I swear under penalty and perjury, to the best of my knowledge, that the above statements are true and correct.*

_____ _____
Employee Signature Date

Fill out this form if you are applying for
**Full Day State Preschool Only**

## AUTHORIZATION TO RELEASE EMPLOYMENT INFORMATION

**Completed by Parent/Guardian 2**

Student's Name_____

_____ _____
Employee Name Company Phone Number

_____ _____
Company Business Name Company Contact Name

_____ _____ _____
Company Address City Zip Code

_____
Company Business Hours

**********

*Twin Rivers Unified School District/Early Learning Department has permission to contact my employer to verify my employment & income information.*
*I swear under penalty and perjury, to the best of my knowledge, that the above statements are true and correct.*

_____ _____
Employee Signature Date

TwinRivers
UNIFIED SCHOOL DISTRICT

STATEMENT OF EARNINGS VERIFICATION - ***For office use only***

***For office use only:***

**Student's Name:** _____

**School:** _____

**Employer:**

_____ _____
Company/Business Name Date

_____
Address

_____ _____
City, State and Zip Phone

I verify that_____is an employee at this establishment.

| | | | |
|---|---|---|---|
| Date of hire | | Rate of pay | |
| Workday hours | | How often paid | |
| Days worked | | | |
| Description of work and pay per month. | | | |

I hereby declare or affirm under penalty of perjury that all the above information is true and correct, that I could and would so testify under oath, if called to do so before any tribunal or officer empowered by the laws of this state to administer oaths.

PLEASE NOTE: "Perjury is punishable by imprisonment in the state prison for two, three, or four years" - PC section 126

_____ _____
Clerk s Signature Date

TwinRivers UNIFIED SCHOOL DISTRICT

**Fill out this form if you are applying for**
**Full Day State Preschool Only**

## Self-Certification of Income *(if applicable)*

Student's Name_____

School: _____

**A. Self-certification of employment income for the following reason:**

1. ◯ The agency has requested that I complete this form because my employer has refused or failed to provide requested employment information.
2. ◯ I have asked that my employer not be contacted to verify my employment because that contact could put my employment at risk.
3. ◯ I have no paystubs, receipts, or other documentation of employment.

| | |
|---|---|
| Employer | |
| Type of work | |
| Rate of pay | |
| How often paid | |
| Description of work and pay for the past month | |

**B. Self-certification of non-employment income when no documentation is possible:**

| | |
|---|---|
| What type | |
| How much | |
| How often | |
| Why | |

**C. Self-certification of $0 income**

For the period of _____ to _____, my income was $0 for the following reason(s):

_____

_____

_____

I swear under penalty of perjury, to the best of my knowledge, that the above information is true and correct.

*** Please note you may be asked for additional documentation.**

Parent/Guardian Name_____

Parent/Guardian Signature_____ Date_____

**For Agency Use Only**

I, _____, attest that the reported income and employment is reasonable or consistent with community practice.

Agency Representative Signature_____ Date_____

TwinRivers
UNIFIED SCHOOL DISTRICT

**Full Day State Preschool Only**
*if applicable*

# Seeking Employment OR Seeking to Increase Employment Declaration

Documentation of Need: Seeking Employment; Service Limitations (EC 8261, 8263, and 8265; 5CCR 18086.5). If the basis of need as stated on the application for services is seeking employment, the parent's period of eligibility for child care and development services is **for not less than 12 months**.

**Declaration**

I, _____ (name), parent/guardian of _____ (child/children's names) do declare under penalty of perjury that I need child care and development services because I am seeking employment.

My reason for seeking employment:

How I plan to secure, change, or increase employment:

**I need child care and development services:**

Days: M ☐ T ☐ W ☐ Th ☐ F ☐ (please check the boxes)

Time: ___:____ ☐am/☐pm to ___:____ ☐am/☐pm

I understand that I must provide additional documentation, as appropriate.

*I hereby declare or affirm under penalty of perjury that all the above information is true and correct, that I could and would so testify under oath, if called to do so before any tribunal or officer empowered by the laws of this state to administer oaths.*

*PLEASE NOTE: "Perjury is punishable by imprisonment in the state prison for two, three, or four years"—PC Section 126*

Signature: _____ Date: _____

Agency Representative: _____ School Site: _____

CALIFORNIA DEPARTMENT OF EDUCATION
Child Development Division
Form CD-9606, (Rev. June 2015)

**NOTE**: When applicable, this form is to be completed and used with form, CD-9600.

**Full Day State Preschool Only**
*if applicable*

# STATEMENT OF PARENTAL INCAPACITY

**PART I – To be completed by the authorized agency representative and the incapacitated parent.**
By signing this form and for the purpose of verifying my incapacity to care for the family's children as it relates to the family's eligibility for subsidized child care and development services, I authorize and request the health professional named in Part II to release the information requested to the agency identified below. I further authorize the health professional to discuss this Statement of Incapacity with the agency in order for the agency to verify, clarify, or complete it. I understand the health professional may also require that I complete his or her own release form prior to providing the information requested below.

| NAME OF PARENT/CARETAKER | SIGNATURE OF PARENT/CARETAKER | DATE |
|---|---|---|
| | | |

**FIRST NAME AND AGE OF THE CHILD(REN) FOR WHOM FINANCIAL ASSISTANCE FOR CHILD CARE IS BEING REQUESTED:**

| 1. | 2. | 3. | 4. |
|---|---|---|---|
| | | | |

| AGENCY | AUTHORIZED AGENCY REPRESENTATIVE (Please print.) | TELEPHONE NUMBER |
|---|---|---|
| **Twin Rivers Unified School District** | **Early Childhood Education Department** | **( 916 ) 566-1616** |

| ADDRESS | CITY | ZIP CODE |
|---|---|---|
| **5115 Dudley Blvd.** | **McClellan** | **95652** |

**PART II – To be completed by the licensed health professional.**
For the family to be eligible to receive child care and development services under the category of incapacity, the California law requires verification, at least annually, of the physical or mental incapacity of the parent or caretaker that renders the person incapable of caring for or supervising the family's child(ren) without assistance. *(See California Code of Regulations, Title 5, §18088.)* Your cooperation in completing and returning this form to the agency listed above within 15 days of receipt is requested.

PATIENT _____ HAS

a ☐ physical condition or

a ☐ mental health condition

that prevents him or her from providing care or supervision for the child(ren) listed above for at least part of the day.

Please indicate the time in a day and the days of the week, not to exceed 50 hours in a week, that the parent is unable to care for or supervise the child(ren).

| Child care | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| Start Time: | am/ pm | am/ pm | am/ pm | am/ pm | am/ pm | am/ pm | am/ pm |
| End Time: | am/ pm | am/ pm | am/ pm | am/ pm | am/ pm | am/ pm | am/ pm |

PROBABLY DATES OF INCAPACITY

From: To:

If the time of day cannot be easily identified in consultation with the patient, please identify the number of hours ☐ and days of the week [M, T, W, T, F, S, S] that services are needed.

*If the parent has a physical/medical condition, please identify the extent to which the parent is incapable of providing care and supervision.*

*Please sign and submit this form to the agency listed in Part I within 15 days of receipt of this form.*

| NAME OF LICENSED HEALTH PROFESSIONAL | LICENSE TYPE | LICENSE NUMBER |
|---|---|---|
| | | |
| SIGNATURE OF LICENSED HEALTH PROFESSIONAL | DATE | TELEPHONE NUMBER ( ) |
| | | |

| MEDICAL GROUP OR ORGANIZATION WITH WHICH THE PROFESSIONAL IS AFFILIATED, IF ANY | | | |
|---|---|---|---|
| | | | |
| ADDRESS | CITY | STATE | ZIP CODE |
| | | | |

# Submit your 20/21 Preschool Application

1. Please click the blue SUBMIT button below. You will not be able to submit if any of the red boxes are not filled in.
2. A box will pop up:
    a. Choose to use your default email or click webmail and add the email you would like to use.
    b. Click continue
3. In the SUBJECT line of the email, if you forgot to rename you application earlier to add you Child's Last Name, First Initial and Date of Birth, please insert this now. For example, Smith, J 01/11/2011 for John Smith with a birthday on January 11, 2011.
4. Attach all necessary documents to your email. If you are missing documents it may delay your enrollment.
    a. Birth Certificate for enrolling student
    b. Birth Certificate for all siblings under age 18 still living at home
    c. Current Proof of Income
    d. Current Proof of Residency (Address)
    e. Immunization Record for enrolling student
    f. Health Evaluation/Physical
    g. Court Documents (if applicable)
    h. IEP/IFSP (if applicable)
    i. Full Day ONLY – Employment/Training Verification
    j. Head Start ONLY – Dental exam
    k. Head Start ONLY – Medical Insurance Card
    l. Head Start ONLY – WIC card (if applicable)
5. Hit the send button and your application will be submitted to the Early Learning Department. Please keep in mind that during this pandemic our staff is teleworking and will respond to your application as soon as possible.

**Click here to Submit Application**