



Tracy Unified School District
School Readiness Preschool Programs



Enrollment Packet

for

California State Preschool Program (3 Hours)

First 5 Preschool (3 Hours)

Located at:

NORTH PRESCHOOL #393614190

2875 Holly Drive, Portable 1 Tracy, CA 95376

SOUTH WEST PARK PRESCHOOL #393605949

550 West Mount Diablo Avenue Tracy, CA 95376

VILLALOVOZ PRESCHOOL #393621310

1550 Cypress Drive Tracy, CA 95376

Appointment: _____
Date Time

School Readiness Preschool Office: 550 West Mount Diablo Ave., Tracy, CA

Please call Marie Martinez, Enrollment Secretary, if you have any questions at 209-830-3355.

2021-2022

Dear Parent/Guardian,

Thank you for your interest in our preschool programs. You will begin the process of being placed on our waiting list for our State Preschool Program or our First 5 Preschool Program by completing the attached forms. We will access our waiting list and contact families based on the eligibility criteria below. For the 2021-2022 school year, your child must be 3 or 4 years old by December 1st of the school year or apply after their 3rd birthday.

California State Preschool Program (CSPP)

Part-day CSPP Admission Priorities (EC 8261, 8235, 8236 and, 8263(b); 5 CCR 18106):

- a. **First Priority:** Contractors shall give first priority for services to CSPP three- and four-year-old children who are recipients of child protective services, or who have been determined to be neglected, abused, or exploited or at risk thereof. If an agency is unable to enroll a child in this first priority category, the agency shall refer the child's parent or guardian to local resources and referral services so that services for the child can be located.
- b. **Second Priority:** (EC 8263[b][2]) Contractors shall give second priority for services to eligible CSPP four-year-old children whose birthdate is from December 3, 2016 to December 1, 2017, not enrolled in Transitional Kindergarten, in the following order: 1) Eligible children who were enrolled in CSPP as a three-year-old; 2) Children whose families have the lowest income ranking based on the most recent Schedule of Income Ceiling eligibility table as published by the SSPI at the time of enrollment; 3) When two or more families have the same income ranking, according to the most recent Schedule of Income Ceiling eligibility table, the child with exceptional needs as defined in EC section 8208 shall be admitted first; 4) If there are no families with children with exceptional needs, the family that has been on the waiting list for the longest time shall be admitted first.
- c. **Third Priority:** Contractors shall give third priority for services to eligible CSPP three-year old children, in the following order: 1) Children whose families have the lowest income ranking based on the most recent Schedule of Income Ceiling eligibility table as published by the SSPI at the time of enrollment; 2) When two or more families have the same income ranking, according to the most recent Schedule of Income Ceiling eligibility table, the child with exceptional needs as defined in EC section 8208 shall be admitted first; 3) If there are no families with children with exceptional needs, the family that has been on the waiting list for the longest time shall be admitted first.
- d. After all otherwise eligible children have been enrolled, the contractor may enroll the following children in the order listed: 1) Children from families whose income is no more than 15% above the eligibility income threshold may be enrolled. Children from families enrolled under this exception may not exceed ten percent of the participating CSPP's total contract enrollment. Priority shall be given to four-year-olds before three-year-olds; 2) Children with exceptional needs as defined in EC Section 8208 may be enrolled, regardless of family's income. Children enrolled pursuant to this subsection, shall not count towards the ten percent limitation. Priority shall be given to four-year-olds before three-year-olds; 3) For CSPP sites operating within the attendance boundaries of a qualified FRPM school, the contractor may, enroll CSPP four-year-old children whose families reside within the attendance boundary of the qualified FRPM elementary school without establishing eligibility pursuant to EC sections 8263(a)(1)(A) and (B). These families shall, to the extent possible, be enrolled in income ranking order, lowest to highest.

Please check the chart below to see if your total countable income qualifies in meeting income eligible criteria. Please include all salaries (refer to attached countable income sheet) when calculating your monthly income.

SCHEDULE OF INCOME CEILING

# of Persons in Family	<u>Family's Total Gross Income</u>	
	Monthly	Yearly
1-2	\$5,540	\$66,479
3	\$6,157	\$73,885
4	\$7,069	\$84,822
5	\$8,199	\$98,393
6	\$9,330	\$111,965
7	\$9,542	\$114,509
8	\$9,755	\$117,054
9	\$9,967	\$119,598
10	\$10,179	\$122,143
11	\$10,391	\$124,687
12 or more	\$10,603	\$127,232

First 5 Preschool Program

To be eligible for our First 5 program, families must meet one or more of the following qualifications or have one of the following:

1. Age eligible 4-year-old with special needs (must be 3 or 4 years old by December 1st of the school year or apply after their 3rd birthday).
2. Reside within the attendance boundaries of one of the following TUSD schools: Bohn, Central, Freiler, Hirsch, Jacobson, Kelly, McKinley, North, Poet Christian, South West Park, or Villalovoz schools.
3. Dual language household.
4. Seasonal migrant household.
5. Low income family.
6. Ethnic household.
7. Experiencing homelessness.
8. Enrolled child in the foster care system.

Please complete the interest forms contained in this packet and gather the required documentation listed on the following page that will need to be submitted along with your packet to our School Readiness Enrollment office located at South West Park Elementary School. Please make sure all your documents are complete, you will be turned away if your packet is not complete at the time of your appointment.

If you have any questions about these forms or if you need help filling them out, please call our School Readiness Enrollment Clerk at 209-830-3355.

Rocio Garcia
School Readiness Coordinator
Tracy Unified School District

Tracy Unified School District
School Readiness Preschool Programs

REQUIRED DOCUMENTATION FOR ENROLLMENT

A final registration appointment is required in order to enroll your child in this program. Based on our priority list, you will be contacted for an enrollment appointment. Bring ALL the required documentation with you to your enrollment appointment. ALL forms must be signed and dated. DO NOT mail these forms.

Proof of Residence:

- ☐ One proof of a street address or post office address in California in your name **OR**
- ☐ One proof of a street address of the primary resident if your family is sharing or renting a room & completed TUSD Student Residency Questionnaire affidavit (both sides).
- ☐ Families experiencing homelessness may submit referral from a social services agency or self-declaration of intent to live in California, no evidence required.

Birth Certificates: for **ALL** children under 18 years of age included in the family size.

Up-to-date Immunization Records: *Must be provided within 30 days of enrollment.*

- ☐ California Immunization Record (yellow card) **OR**
- ☐ Immunization Summary Report: if your child's immunization records are from another country, please have them translated at your child's doctor office.

Physical Exam of child: *Must be provided within 30 days of enrollment.*

- ☐ Physician's Report LIC701 – must be completed by doctor after child's 4th birthday (form included in your packet).

Documentation of total family income: showing **one month's** worth of the family's most recent total gross monthly income (see attached eligible income worksheet for more details).

- ☐ **Weekly Pay:** provide 4-5 consecutive payroll stubs.
- ☐ **Bi-Weekly Pay:** provide 2-3 consecutive payroll stubs.
- ☐ **Monthly Pay:** provide 1 payroll stub from the previous month.
- ☐ **Self-Employed:** letter from source of income, copy of most recently signed AND completed business tax returns with a statement of current estimated income for tax purposes, or other business records (ledgers/receipts/business logs).
- ☐ Child Support/Alimony/TANF Payments & verification of any other income; Unemployment/Disability/Workers Compensation.

COUNTABLE/NON-COUNTABLE INCOME REFERENCE SHEET

Countable Income is income of individuals counted in the family size that shall be included when calculating the adjusted monthly income for purposes of determining income eligibility.	Non-Countable Income is income of individuals counted in the family size that shall be excluded when calculating the adjusted monthly income for purposes of determining income eligibility.
<ol style="list-style-type: none"> 1. Gross wages or salary, advances, commissions, overtime, tips, bonuses, gambling or lottery winnings; 2. Wages for migrant, agricultural, or seasonal work; 3. Public cash assistance; 4. Gross income from self-employment less business expenses with the exception of wage draws; 5. Disability or unemployment compensation; 6. Workers compensation; 7. Spousal support, child support received from the former spouse or absent parent, or financial assistance for housing costs or car payments paid as part of or in addition to spousal or child support; 8. Survivor and retirement benefits; 9. Dividends, interest on bonds, income from estates or trusts, net rental income or royalties; 10. Rent for room within the family's residence; 11. Foster care grants, payments or clothing allowance for children placed through child welfare services; 12. Financial assistance received for the care of a child living with an adult who is not the child's biological or adoptive parent; 13. Veterans pensions; 14. Pensions or annuities; 15. Inheritance; 16. Allowances for housing or automobiles provided as part of compensation; 17. Portion of student grants or scholarships not identified for educational purposes as tuition, books, or supplies; 18. Insurance or court settlements for lost wages or punitive damages; 19. Net proceeds from the sale of real property, stocks, or inherited property; or 20. Other enterprise for gain. 	<ol style="list-style-type: none"> 1. Earnings of a child under age eighteen (18) years; 2. Loans; 3. Grants or scholarships to students for educational purposes other than any balance available for living costs; 4. Food stamps or other food assistance; 5. Earned Income Tax Credit or tax refund; 6. GI Bill entitlements, hardship duty pay, hazardous duty pay, hostile fire pay, or imminent danger pay; 7. Adoption assistance payments received pursuant to Welfare and Institutions (W&I) Code Section 16115 et seq.; 8. Non-cash assistance or gifts; 9. All income of any individual counted in the family size who is collecting federal Supplemental Security Income (SSI) or State Supplemental Program (SSP) benefits; 10. Insurance or court settlements including pain and suffering and excluding lost wages and punitive damages; 11. Reimbursements for work-required expenses such as uniforms, mileage, or per diem expenses for food and lodging; 12. Business expenses for self-employed family members; 13. When there is no cash value to the employee, the portion of medical and/or dental insurance documented as paid by the employer and included in gross pay; and 14. Disaster relief grants or payments, except any portion for rental assistance or unemployment.

Tracy Unified School District School Readiness Preschool Programs

Authorization to Release Employment Verification

I give my permission for information regarding my employment to be released to the Tracy Unified School District's Preschool Program to determine child care eligibility for my child/ren. I understand that falsifying any information regarding employment will make me ineligible for preschool services and can result in prosecution by the District Attorney's office.

Employee's Name – Please print

Birth date

Employee's Signature

Date

BUSINESS NAME

BUSINESS PHONE #

BUSINESS ADDRESS

CITY / STATE

ZIP

FAX PHONE #

THIS SECTION TO BE COMPLETED BY EMPLOYER ONLY

Phone # where employee can be reached during working hours_____

Employee's Classification_____ First day of Employment_____ Last day, if known_____

Gross Monthly Salary \$_____ (include tips, overtime and commission)

HOW OFTEN IS EMPLOYEE PAID:

Monthly_____

Weekly_____

Every 2 weeks_____

2 times per month_____

Work Days:

MON_____

TUE_____

WED_____

THU_____

FRI_____

SAT_____

SUN_____

Hours of Employment:

From_____

To_____

I certify under that the information regarding his/her employment is accurate.

Employer or Designee Signature_____

Title_____

Date_____

OFFICE USE ONLY

Working Parent	Date Verified	Verified With (name)	Staff Initials
Parent A:			
Parent B:			

Verification notes:

(Please PRINT) **TRACY UNIFIED SCHOOL DISTRICT PRESCHOOL REGISTRATION FORM** (11/11)

*The California State Department of Education requires districts to collect the following background information on students for state tests and reports. This information will remain confidential and is not included in any of the student's individual testing reports.

◆Student's LEGAL Name: (Name as it appears on the Birth Certificate)

Last First Middle Grade

Sex: M F _____
Date of Birth _____

Parent #1/Guardian Name Relationship
Parent with whom the child resides

Parent #1 Home Phone & Email Address

Parent #1 Cell Phone

Parent #1 Work Phone

Parent #1 Residence Address, City, Zip Code

Parent #1 Mailing Address (if different from residence)

Parent #2/Guardian Name Relationship

Parent #2 Home Phone & Email Address

Parent #2 Cell Phone

Parent #2 Work Phone

Parent #2 Residence Address (if different from Parent #1)

Parent #2 Mailing Address (if different from residence)

Has your student ever attended Tracy Unified? ___ Yes ___ No If yes, what school? _____

Is your child currently under an expulsion order? ___ Yes ___ No

Has s/he ever been expelled from school? ___ Yes ___ No

If yes, date _____

City/State _____ School _____

Language Dominance Information (Home Language Survey):

1. What language did your child learn when first beginning to talk? _____
2. What language do you use most frequently to speak to your child? _____
3. What language does your child most frequently use at home? _____
4. What language is most often spoken by the adults at home? _____

Office Use Only

School _____ Res Sch _____

Grade _____ ID# _____

Teacher _____ Rm _____

District Enrollment Date _____

School Enter Date _____

Expected Graduation Date _____

Date Initials

_____ Registration Information Sheets

_____ Current Address/Parent pic ID Verification

_____ Utility Bill (form) _____

_____ Proof of Birth(K-12) Form _____

_____ Physical (K-1)

_____ Immunization Record

_____ Oral Health Exam (K)

_____ Emergency Form

_____ Internet Agreement

_____ Review Records/Rights Notification

_____ CUM file request

_____ Discipline Handbook/Card

Last School Attended _____

City/State _____

District Name _____

Has your child ever repeated the same grade?

___ Yes ___ No

If yes, what grade? _____

◆All students shall be recorded and referred to by their legal surname, as documented in a legally acceptable birth record or in a court order of change of name. A request from a parent or a student that a student's surname be changed in school records will not be honored without legal documentation, or special permission from the superintendent or designee.

(Over)

***What Is Your Child's Ethnicity? (Please check one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

***What is your Child's Race? (Please check up to 5 racial categories)**

_____ African American/Black (600)	_____ Cambodian (207)	_____ Hawaiian, Native (301)	_____ Laotian (206)	_____ Vietnamese (204)
_____ American Indian/Alaskan Native (100)	_____ Chinese (201)	_____ Hmong (208)	_____ Pacific Islander, Other (399)	_____ White (700)
_____ Asian Indian (205)	_____ Filipino (400)	_____ Japanese (202)	_____ Samoan (303)	
_____ Asian, other (299)	_____ Guamanian (302)	_____ Korean (203)	_____ Tahitian (304)	

*** Education Level of student's most educated parent:** (Mark only 1)

___ Not a high school graduate (1) ___ Some college (3) ___ Graduate School/Post Graduate training (5) ___ High school graduate (2) ___ College graduate (4) ___ Decline to state or unknown (6)

***Place of Birth:** City _____ State _____ Country _____ ***Date your child first entered the United States (if born outside the US):** _____
(MM/DD/YYYY)

***Date your child first enrolled in a school in the United States:** _____ ***Date your child first entered a California School:** _____
(MM/DD/YYYY) (MM/DD/YYYY)

Student resides with: Parent (1) ___ Parent (2) ___ Both Parents (BP) ___ Joint Custody (JC) ___ Guardian (G) ___ Foster Parent (FP) ___ Other (O) _____

Is there any LEGAL or GUARDIANSHIP information about your child we should be aware of? **Yes** ___ **No** ___ *If YES, attach copies of applicable LEGAL DOCUMENTS.*
Parents must complete the Educational/Medical Rights form for Step-Parents to have rights.

These documents must be on file in the school office.

Is your child known by another name? **Last Name** _____ **First Name** _____

Special Program Participation (Please check any exceptional student programs your child has been enrolled in)

Special Program

_____ Title I
_____ GATE
_____ 504

Special Educational Services:

_____ Resource Program (RSP)
_____ Special Day Class (SDC)
_____ Speech Therapy (LSH)
_____ Adaptive PE

English Learner:

_____ Bilingual
_____ English Immersion
_____ Migrant Education
_____ ELD
_____ Other: _____

Does your child have any MEDICAL/HEALTH problems we should be aware of? ___ **Yes** ___ **No**

*If yes, please complete appropriate area on **EMERGENCY FORM** and attach any additional information needed.*

BROTHERS, SISTERS, OTHERS IN YOUR HOME ENROLLED IN TRACY UNIFIED: (Please give name, relationship, birth date and grade)

Name: _____ Relationship: _____ Birth date: _____ Grade: _____

Name: _____ Relationship: _____ Birth date: _____ Grade: _____

Name: _____ Relationship: _____ Birth date: _____ Grade: _____

Parent/Guardian Signature

Date

TUSD Authorized Signature

Date



Name of Student _____ Grade _____

SITE USE ONLY
Initial: _____
Date: _____

Student Residency Questionnaire

(One questionnaire required per student)

This form must be completed at the beginning of every school year by all parents/guardians and/or unaccompanied youth. The information provided on this form can assist with identifying students who qualify for services under the McKinney-Vento Act (Transitional Housing).

Parent #1/ Guardian Name: _____ Relationship to Student: _____

Current Residence Address: _____

How long have you been at this location? _____ Phone Number: _____

Parent #2/ Guardian Name: _____ Relationship to Student: _____

Current Residence Address: _____

How long have you been at this location? _____ Phone Number: _____

*****Note: If legal custody is split between two parents, in addition to the documents listed below, you will need to attach a certified copy of the court order identifying each parent's respective award of physical custody. You are responsible to immediately inform the school of any changes to the court order. *****

PLEASE LIST ALL OF THE PRESCHOOL AND SCHOOL-AGED CHILDREN LIVING IN YOUR HOME:

Name: _____	Birthdate: ____/____/____	School: _____	Grade: _____
Name: _____	Birthdate: ____/____/____	School: _____	Grade: _____
Name: _____	Birthdate: ____/____/____	School: _____	Grade: _____
Name: _____	Birthdate: ____/____/____	School: _____	Grade: _____
Name: _____	Birthdate: ____/____/____	School: _____	Grade: _____

Are any of your students in foster placement? ☐ YES ☐ NO

(If you answer YES, please complete a Foster Student Questionnaire for each foster student.)

PLEASE CHECK THE BOX BELOW THAT BEST DESCRIBES YOUR CURRENT LIVING SITUATION:

- ☐ Rent/own apartment or home (IF CHECKED, GO TO STEP A)
- ☐ Preferred Sharing Home or Long-Term Living Arrangements (IF CHECKED, GO TO STEP B)
- ☐ Sharing the housing of other person due to (CHECK ONE, AND GO TO STEP C):
 - ____ Loss of housing, economic hardship or a similar reason such as evicted from home
 - ____ Living in a motel, hotel, campground, trailer park or similar setting
 - ____ Living in emergency or transitional such as domestic violence or homeless shelters or in transitional housing
 - ____ Have a primary nighttime residence that is a place not designed for or ordinarily used as a regular sleeping accommodation
 - ____ Sleeping in cars, parks, public spaces, abandoned buildings, substandard housing or similar settings
 - ____ Living with an adult that is not a parent or legal guardian, or living alone without an adult
 - ____ Political Asylum

- A. If you own or rent the property in which you reside, please attach 1 of these items with **your name (PARENT/GUARDIAN)** & current address:
- a. Recent copy of mortgage/rental agreement OR San Joaquin County Tax Bill
 - b. Recent copy of utility bill (PGE, City of Tracy, etc.)
 - c. One other recent bill mailed to you at your address OR Current Driver's License or California ID from the DMV with updated address.
- B. If you are sharing a home with another individual or family, please attach 1 of these items with **their name (PRIMARY RESIDENT)** and current address and complete a **RESIDENCY AFFIDAVIT** form **in person**:
- a. Recent copy of mortgage/rental agreement OR San Joaquin County Tax Bill
 - b. Recent copy of utility bill (PGE, City of Tracy, etc.)
 - c. One other recent bill mailed to them at their address OR Current Driver's License or California ID from the DMV with updated address.

If you would like to receive information regarding available resources, please complete Housing Questionnaire: [HERE](#)

The address listed above is my primary residence. I agree to notify TUSD immediately if there is any change in the status of my residency. I certify that all the information provided is true and correct. I am aware that District Officials may verify the information on the application and that deliberate misrepresentation of the information may subject me to prosecution or other penalties under District, State and Federal Laws.

Parent/Guardian Signature: _____ Date: _____

Student's Name: _____ Birthdate: _____ Grade: _____ Teacher: _____

TRACY UNIFIED SCHOOL DISTRICT EMERGENCY TREATMENT FORM

Note: *If the information listed below changes at any time during the school year, notify the office immediately!*

The Tracy Unified School District's Emergency Treatment Policy for student injury and illness at school permits school personnel to dial "911", the emergency telephone number. With authorization, emergency medical treatment can be provided. For other than life-sustaining treatment, the medical professionals require the parent/guardians' authorization before emergency treatment can be administered.

In the event of serious injury or illness, school personnel will immediately attempt to notify the parent/guardian. If the parent/guardian cannot be reached, and this form is on file in the school office, the school will be authorized to arrange transportation of the student for emergency medical treatment. This form also authorizes a medical professional on duty to perform emergency treatment.

Please complete this form below and return it immediately to your child's school to be placed on file in the school office. Thank you for your cooperation. **PLEASE PRINT LEGIBLY**

Parent/Guardian's name with **whom child is residing**: _____

Circle if Parent or Guardian

Parent #1/Guardian's Name: _____ Address: _____ **Check if**
New Address: _____

Employer Name/address: _____ House # _____ Cell# _____ Work# _____

Parent #2/Guardian's Name: _____ Address: _____ **Check if**
New Address: _____

Employer Name/address: _____ House # _____ Cell# _____ Work# _____

Emergency contact persons by priority, if unable to contact parent/guardian: Please **list LOCAL names**, if possible.

1. Name: _____ Relationship: _____ Phone #: _____ Cell # _____

2. Name: _____ Relationship: _____ Phone #: _____ Cell # _____

3. Name: _____ Relationship: _____ Phone #: _____ Cell # _____

4. Name: _____ Relationship: _____ Phone #: _____ Cell # _____

Does your child have any medical disorders that the school/doctor should be aware of before treatment? Please describe:

Doctor's Name: _____ Phone #: _____

Insurance Company name: _____ Policy #: _____

AUTHORIZATION FOR EMERGENCY TREATMENT AND TRANSPORTATION

I authorize Tracy Unified School District to dial "911" and to arrange emergency transportation to an emergency treatment center or hospital for my child is s/he is seriously injured or ill.

The undersigned has authorized necessary emergency treatment for the patient whose name appears above and that the treatment and procedures will be performed by medical professionals. The undersigned understands that a personal physician is to be selected by, or on behalf of, the patient within 24 hours if hospitalization or further treatment is required, or immediately, if complications arise.

Financial Responsibility: Parents are reminded that financial responsibility including all costs of paramedic, transportation, hospitalization, and any examination, treatment, or x-ray provided shall be the parent/guardian's responsibility should emergency treatment become necessary.

The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the result that may be obtained. This authorization for emergency treatment and transportation will remain in effect during the time the student is enrolled in a Tracy Unified School District School or program. Authorization is also hereby granted for release to all insurance companies and agencies such information as may be necessary for completion of hospitalization claims.

Parent/Guardian Signature: _____ **Date:** _____

(Feb. 5, 2010)

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					
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					
PERSON RESPONSIBLE FOR CHILD	LAST	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 PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

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

DATE OF ADMISSION	LAST DATE OF ENROLLMENT

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

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

TRACY UNIFIED SCHOOL DISTRICT
FACILITY NAME TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

NAME . THIS CARE MAY BE GIVEN UNDER

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

()

CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME	SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE 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
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping Cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*	
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*	
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST		
	LUNCH		
	DINNER		
WHAT ARE USUAL EATING HOURS?	BREAKFAST		
	LUNCH		
	DINNER		
ANY FOOD DISLIKES?		ANY EATING PROBLEMS?	
IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT / AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S HEALTH

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

PARENT/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, 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/AUTHORIZED REPRESENTATIVE SIGNATURE

DATE



Tracy Unified School District
School Readiness Preschool Programs



MEDIA CONSENT AND RELEASE FORM

Tracy Unified School District (TUSD) or First 5 San Joaquin (F5SJ) occasionally takes photos, makes videos, or writes stories about the families being served in F5SJ funded programs. I understand that photographs or videos taken of me or my child and statements made by me or my child while participating in the program may be used in communication materials. I hereby give TUSD/F5SJ permission to:

- Take my and/or my child's photo.
- Make a video-recording of me and/or my child.
- Use statements made by me and/or my child.

In addition, I give permission to TUSD/F5SJ and its affiliates to use stories, pictures, and/or videos in a variety of ways that may include, but are not limited to: newsletters, brochures, websites, magazines, social media, and newspapers. I further understand that my name and my child's name will not be published. Images and content may be used without any further notification.

DATE

CHILD'S NAME

PARENT/GUARDIAN'S SIGNATURE

PARENT/GUARDIAN'S PRINTED NAME

WITNESS

*Parent or Guardian **must** sign for children under 18 years of age, this includes teen parents.

FY 2021-2022





**TRACY UNIFIED SCHOOL DISTRICT
SCHOOL READINESS PRESCHOOL PROGRAM**



WALKING FIELD TRIP RELEASE FORM

I give permission for my child to take part in on-campus field trips or walks in the vicinity of the campus that are arranged and supervised by staff. I understand, however, that I will be notified in advance of any off-campus field trips that involve transportation by car or bus and that I will be asked to complete additional parent permission forms for any such field trip.

Child's Name

Parent Signature

Date

**DISTRITO ESCOLAR UNIFICADO DE TRACY
PROGRAMA PREESCOLAR DE PREPARACIÓN ESCOLAR**

FORMA DE PERMISO PARA EXCUSIONES A PIE

Doy permiso para que mi hijo/a participe en excursiones o caminatas en el campus o en los alrededores del campus, organizados y supervisados por el personal. Sin embargo, entiendo, que se me notificará con anticipación de cualquier excursión fuera del campus que implique transporte en automóvil o autobús y que se me pedirá que llene formas adicionales de permiso de los padres para cualquier excursión de este tipo.

Nombre del Niño/a

Firma del Padre/tutor

Fecha

PHYSICIAN'S REPORT—CHILD CARE CENTERS (CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____. This Child Care Center/School provides a program which extends from _____ : _____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

(SIGNATURE OF PARENT, 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) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	
HIB MENINGITIS (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: _____
Address: _____
Telephone: _____

Date of Physical Exam: _____
Date This Form Completed: _____
Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

PARENTS' GUIDE TO IMMUNIZATIONS REQUIRED FOR PRE-KINDERGARTEN (CHILD CARE)



Starting July 1, 2019

Parents must show their child's Immunization Record as proof of immunizations (shots) before starting pre-kindergarten (child care) and at each age checkpoint after entry:

Age at Entry/checkpoint	Required Doses
2–3 Months	1 Polio 1 DTaP 1 Hep B 1 Hib
4–5 Months	2 Polio 2 DTaP 2 Hep B 2 Hib
6–14 Months	2 Polio 3 DTaP 2 Hep B 2 Hib
15–17 Months	3 Polio 3 DTaP 2 Hep B 1 Hib* (on or after 1st birthday) 1 Varicella 1 MMR (on or after 1st birthday)
18 Months–5 Years	3 Polio 4 DTaP 3 Hep B 1 Hib* (on or after 1st birthday) 1 Varicella 1 MMR (on or after 1st birthday)

* One Hib dose must be given on or after the 1st birthday regardless of previous doses.
Required only for children younger than 5 years old.

DTaP = [diphtheria toxoid](#), [tetanus toxoid](#), and acellular [pertussis](#) vaccine
 Hep B = [hepatitis B](#) vaccine
 Varicella = [chickenpox](#) vaccine

Hib = [Haemophilus influenzae, type B](#) vaccine
 MMR = [measles](#), [mumps](#), and [rubella](#) vaccine