Preschool
Continuation Packet Checklist

If you are looking to continue preschool services through our program, please complete the attached packet and return to Capital City Child Development Center located at 7220 24th Street or Hiram Johnson Family Education Center located at 3535 65th Street. Please bring in your *current paycheck stubs for the last month (30 days)*, a copy of your PG&E or SMUD bill if your address has changed, and a copy of your child's latest physical and dental examination. If you are second year returning, Head Start parent, income is not required.

This packet includes:

- ☐ Emergency Card
- ☐ Health and Development History, 2nd Year
- ☐ Parent/Guardian Notification and Consent Form
- ☐ TB Risk Assessment
- ☐ Lead Poisoning Questionnaire
- ☐ Privacy Notice and Consent Form
- ☐ Child Abuse Reporting
- ☐ Notification of Parent Rights
- ☐ Personal Rights Form
- ☐ SCUSD Volunteer Form
- ☐ Volunteer Sex Offender Check
- ☐ Family Worksheet
- ☐ Parent TB Waiver
- ☐ Physical form
- ☐ Dental form

If you have any questions, please call Capital City Child Development Center at (916) 433-2736 or Hiram Johnson Family Education Center at (916) 277-7151.

Sacramento City Unified School District
Complete All Information on Both Sides

EMERGENCY CARD (revised 7/19/12)
CONFIDENTIAL

Student Information
Please Print

Student's Last Name (Legal) First Name Middle

School Year

School

Office Use Only
Teacher/Cnslr. _____
Grade _____ Room _____ Bus _____
CONCAP [ ] Hm. Sch. _____
Sp. Ed. [ ] RSP [ ] Eth. Cd [ ]

Street Address Apt # Zip Code

Date of Birth

Home Phone (1) _____ Home Phone (2) _____

LANUAGE SPOKEN AT HOME:

Last School of Attendance_____City_____

Parent/Guardian 1 Name

Address_____

Relationship_____ Driver's Lic. # _____

Name & Address of Employment

Work Phone: _____

Cell Phone: _____

Pager: _____

E-mail address

Parent/Guardian 2 Name

Address_____

Relationship_____ Driver's Lic. # _____

Name & Address of Employment

Work Phone: _____

Cell Phone: _____

Pager: _____

E-mail address

Day Care Provider: _____ Phone #1: _____ Phone #2 _____

List names of other children attending this school:

School is authorized to share my phone number with the PTA:
Yes _____ No _____

Check here if student will be riding the bus:
Yes _____
Bus Number: _____

Parent/Guardian with whom the child lives _____ Phone _____

If the parents are divorced or separated, to whom has physical custody been given? **(attach verification)** _____

Please Read:
The parent/guardian is responsible for keeping the school informed of updates or changes to the student's emergency information. The school shall be notified, in writing, of telephone or address changes within three days (3) of the occurrence. If the school is unable to reach anyone on this card in an emergency or if a student is left unattended during non-school hours, the school will contact law enforcement or Child Protective Services.

I have read this and understand my responsibility. _____ *Parent / Guardian Signature*

Note: The adults listed below are authorized to pick up and care for the above-named student. The student may be released to others with written or verbal authorization.

Name 1: _____
Phone: _____ Relationship _____

Name 2: _____
Phone: _____ Relationship _____

Name 3: _____
Phone: _____ Relationship _____

Name 4: _____
Phone: _____ Relationship _____

Name 5: _____
Phone: _____ Relationship _____

Name 6: _____
Phone: _____ Relationship _____

Name 7: _____
Phone: _____ Relationship _____

Name 8: _____
Phone: _____ Relationship _____

Special instructions / comments / (Include instructions for pickup of student):

CONTINUE ON REVERSE SIDE

Sacramento City Unified School District
Complete All Information on Both Sides

EMERGENCY CARD (revised 7/19/12)
CONFIDENTIAL

Student Information
Please Print

General Health Information

☐ **CHECK HERE IF THERE ARE NO HEALTH PROBLEMS.**

Does student wear glasses or contact lenses? ☐ Yes ☐ No

Does student wear hearing aids or is the student diagnosed with hearing loss? ☐ Yes ☐ No

PLEASE CHECK ALL THAT APPLIES TO YOUR CHILD:

☐ ADD/ADHD
☐ Asthma
☐ Diabetes ☐ Type I ☐ Type II
☐ Frequent ear infections
☐ Eczema
☐ Fainting Spells
☐ Frequent Headaches
☐ Heart Problems
☐ Seasonal Allergy
☐ Frequent nosebleeds
☐ Seizures
☐ Severe Allergy
☐ Epi-pen

Other:_____

LIST ALL MEDICATION, WITH DOSE, TAKEN BY YOUR CHILD

AT HOME _____

AT SCHOOL _____

Does student have condition that limits participation in: classroom ☐ physical education ☐

Explain: _____

(NOTE: The physician must provide a note explaining the limitation and reason for the student's limited participation in physical education and the note *must be updated every school year*)

SPECIAL INSTRUCTIONS/COMMENTS: List any special health needs or medical problems, including specific allergic reactions (food, bee sting, etc.), if student has an active emergency care plan, medical 504 Plan, Diabetic Medical Management Plan, etc.

_____

_____

_____

_____

_____

_____

Please Read:

* **California Education Code 49408 states that school districts may require that emergency information be kept current.**

** **The parent or legal guardian of a public school pupil on a continuing medication regimen shall inform the school nurse or other designated certificated employee of the medication being taken.**

*** **California Education Code 49423 requires that if medications are to be taken at school, there must be a medication form on file at school, signed by both parent and physician.**

EMERGENCY AUTHORIZATION

In the event of an emergency, when a parent/guardian is unavailable, I authorize school personnel to make such arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgment. I further authorize the physician named below to undertake such care of my child, as he/she considers necessary. In the event said physician is not available, I authorize such care and treatment to be performed by a licensed physician or surgeon. I understand that the parent or guardian is responsible for the cost of such emergency care.

Physician Name _____ Phone _____ Pager _____

Emergency Facility/Phone _____

Does this student have Health Insurance? ☐ **Yes or No** ☐ **Does this student have Dental Insurance?** ☐ **Yes or No** ☐

Name of Insurance Coverage or Health Plan Provider: _____ Student's Medical Record Number _____

If not, I give permission to SCUSD to share this information to help apply for health insurance for my child. ☐ **Yes** ☐ **No**

I certify that the information is true and correct.

Parent/Guardian Signature _____ **Date** _____

CONTINUE ON REVERSE SIDE

Sacramento City Unified School District
CHILD DEVELOPMENT DEPARTMENT

UPDATED HEALTH HISTORY – CONTINUING PRESCHOOL STUDENTS

Child's Name: _____ DOB: _____
Parent/Caregiver Name: _____ PHONE: _____

Insurance: ☐ Medi-Cal ☐ Healthy Families ☐ Private ☐ None
Doctor's Name: _____ Plan: _____
Dentist's Name: _____ Plan: _____
Doctor's Phone: _____ Dentist's Phone: _____

FOR FAMILY HEALTH, PREGNANCY AND BIRTH HISTORY: SEE INITIAL ENROLLMENT HEALTH HISTORY

CHILD HEALTH HISTORY

☐ Yes ☐ No Has an ongoing health problem (asthma, anemia, sickle cell disease, cerebral palsy, seizures, etc.)
Explain: _____ Date of Diagnosis: _____
MD Specialist: _____ Next Appointment: _____
☐ Yes ☐ No Emergency Room visits Explain: _____
☐ Yes ☐ No Has had prior surgery (ies), Type/s _____ Date: _____
☐ Yes ☐ No Takes prescription medication/s, **Name & Dose/s:** _____
☐ Yes ☐ No Needs medication in class (For Center-Based students)
☐ Yes ☐ No Is your child allergic to any medicine? If so, please name: _____
☐ Yes ☐ No Seasonal (airborne) Allergies/ Eczema. Describe: _____
☐ Yes ☐ No Is your child allergic to any food? Name of food/s: _____
Describe reaction: rash, swelling, difficulty breathing, etc. _____
☐ Yes ☐ No Has your child been prescribed an Epi-pen or Benadryl for this food allergy?
☐ Yes ☐ No Has there been any change in your child's diet or eating behavior since last year?
☐ Yes ☐ No Do you have any concerns about your child's diet or eating behavior?
☐ Yes ☐ No Is your child on any special diet? Please explain: _____
☐ Yes ☐ No Constipation/Diarrhea
☐ Yes ☐ No Problems with mouth, gums, and teeth (including cavities)
☐ Yes ☐ No More than two ear infections/ year
☐ Yes ☐ No Current hearing problem/ Tubes in ears
☐ Yes ☐ No Speech concerns Explain: _____
☐ Yes ☐ No Has trouble with his/her eyes (squints, eyes cross, etc.)
☐ Yes ☐ No Has glasses prescribed
☐ Yes ☐ No Exposure to tobacco smoke
Please explain any items you answered with YES: _____

_____

Is your child seeing a specialist? If so, please check all that applies:
☐ Audiologist ☐ ENT (ear, nose, throat) ☐ Neurologist
☐ Optometrist (eye) ☐ Speech Therapist ☐ Other: _____
Has your child ever received services from:
☐ Alta Regional Center ☐ California Children Services (CCS) ☐ MIND Institute (UCD)
☐ Shriner's Hospital ☐ Special Education Services ☐ Other: _____
☐ WIC If currently receiving WIC, please list child's WIC number: _____
Please give name and phone number of any specialists checked above: _____

_____

Parent Signature: _____ Date: _____ Nurse Review: _____ Date: _____

Distribution: White – Child's Class File Yellow – Health Cum

Sacramento City Unified School District
CHILD DEVELOPMENT DEPARTMENT

PARENT/GUARDIAN NOTIFICATION AND CONSENT FORM

All information is kept confidential

Child's Name: _____Preschool/Site: _____ ☐AM ☐PM ☐ Full-Day

We operate under federal, state, district and program guidelines to provide safe and developmentally appropriate experiences for your child. This form provides information regarding our program requirements and also program services that are designed to identify any health and learning problems that may interfere with your child's learning experiences now and in future years. We encourage you to be actively involved in your child's health care and school related activities.

NOTIFICATIONS:

Our programs require all enrolled children to have up-to-date immunizations (including a current TB skin test). In addition, all enrolled children must have a complete physical examination within 30 days of enrollment and an annual dental examination.

_____ *Initials* I understand that failure to provide this information within the required timelines may result in my child's termination from the program.

Our programs are licensed by the Department of Social Services and comply with the following regulation: Inspection Authority**/**Dept. of Social Services – Title 22, Division 12, Chapter 1, Article 4, Section 101200(b)(1)(c)(1)(d)

_____ *Initials* I understand that the **Department of Social Services has the authority to**:
(b) interview children or staff without prior consent,
(c) inspect, audit, and copy child or child care center records upon demand during normal business hours
(d) observe the physical condition of the children, including conditions that could indicate abuse, neglect or inappropriate placement.

Our programs enroll out-of-district children, with priority enrollment provided to SCUSD residents. When an out-of-district child becomes kindergarten eligible, he/she must register at his/her district's school of attendance.

_____ *Initials* I understand that I must enroll my child in his/her district's school of attendance when he/she becomes eligible for kindergarten (5 on or before September 1st).

CONSENTS:

1. Screening: I consent to have my child screened in the following areas:

☐Yes ☐No - Hearing/Vision ☐Yes ☐No - Height/Weight ☐Yes ☐No - Social/Emotional
☐Yes ☐No - Speech/Language ☐Yes ☐No - General development

2. Observation: I consent to have my child observed by the Child Development Department's support staff with the understanding that I will be informed prior to these observations and provided the opportunity to provide my written authorization for these services.

☐Yes ☐No

3. Assessment: I consent to have my child assessed in the following area, using the following assessment tools:

☐Yes ☐No - General Development, "DRDP-R" or "Learning Games Assessment Instrument" *(Home-Based only)*

4. Field Trips: I consent to have my child participate in field trips with the understanding that I will be notified in advance of each trip.

☐Yes ☐No

5. Photographs: I consent to have my child photographed for the purposes of display in the classroom, posters, or for use in publications dealing with early childhood education.

☐Yes ☐No

6. Forwarding Records: I consent to have my child's records forwarded to the next school of attendance, or when another district requests the records (exception: special education records).

☐Yes ☐No

Parent/Guardian

Print:_____**Sign:** _____ **Date:** _____

Distribution: Original – child's file Copy – parent/guardian

GC: 06/08

Sacramento City Unified School District
Child Development Department

Head Start/Early Head Start TB* Risk Assessment

Child's Name: _____ DOB: _____

1	**Has the child come in close contact with a person infected with tuberculosis (TB)?**	**Yes**	**No**
2	**Is the child foreign born, a refugee or a migrant?**	**Yes**	**No**
3	**Has the child had contact with an incarcerated person or a person who has been incarcerated in within the last 5 years?**	**Yes**	**No**
4	**Has the child been exposed to any of the following individuals: 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**
5	**Does the child have a medical condition which suppresses the immune system?**	**Yes**	**No**
6	**Does the child live in a community in which it has been established that a high risk exists for TB?**	**Yes**	**No**
7	**Has the child traveled to any foreign countries since the last medical visit?**	**Yes**	**No**

Parent/Guardian Signature: _____ Date: _____

Please note:

If you have answered "Yes" to any of the above questions, please refer to your child's Health Care Provider for possible TB testing.

*Tuberculosis (TB) is caused by a bacterium that usually infects the lungs, but the TB bacteria can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal. TB is spread through the air from one person to another by coughing, sneezing, speaking, or singing. People nearby may breathe in these bacteria and become infected. If you think you have been exposed to someone with TB disease, contact your health care provider or local health department to see if you should be tested for TB infection.

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT

Childhood Lead Poisoning Questionnaire

(A survey to determine a child's risk for lead poisoning)

- **Parent or Guardian:** Answer these questions about your child and give this form to his/her doctor.
  Complete one survey for each child less than 6 years old.

Child's Name: _____ **Birthdate:** _____

School: _____

A. Is your child receiving services for CHDP, Healthy Families, Medi-cal and/or WIC?	Yes	No
B. Does your child live in or visit a place built before 1978 or that has recently been remodeled? (For ex: Day care center, Baby-sitter/Family/Friend/Neighbor's home……)	Yes	No

Parent or Guardian: Other risk factors for lead poisoning:

1. Does your child know someone who has lead poisoning (Blood lead level >15 ug/dL)? (For example, a parent, brother/sister, cousin, friend…)	Yes	No
2. Does your child live with someone who works with lead? (For example, person is a construction worker (fixes old houses), mechanic (fixes car batteries and radiators), works with scrap metal, solders (fixes) wires or electronics, makes ceramics/pottery/stained glass/jewelry…)	Yes	No
3. Do you have vinyl (plastic) miniblinds (vertical or horizontal) or old bath tubs in your home?	Yes	No
4. Does your child frequently put objects in his/her mouth and/or eat non-food items? (For example, child eats dirt, paint chips, chews on windowsills or fishing weights…)	Yes	No
5. Is your child anemic (lacking iron)? (Hemoglobin <11mg/dL or Hematocrit <33%)	Yes	No
6. Is your child given home remedies or wear make up from another country? Common in these communities — Home remedies/cosmetics Latino — *Azarcon, Alarcon, Greta, Albayalde, Liza Maria,* Hmong — *Luisa Coral, Rueda, Pay-loo-ah* Arabic/Middle Eastern — *Kohl, Alkohl, Sattarang, Bokoor, Ceruse, Cerrusite,* Asian-Indian — *Ghasard, Bala goli, Kandu, Surma*	Yes	No
7. Does your child eat foods stored/cooked in old/imported pottery/dishes or eat Mexican candy?	Yes	No
8. Did your child live or spend some time in another country? Where and When?	Yes	No

- **Parent or Guardian**
  - ☐ If you answered "Yes" to any of the questions, your child may be at risk for lead poisoning and needs a blood test.
  - ☐ If you answered "No" to all the questions above, your child is not at risk for lead poisoning at this time.

❋ **Doctor: This child may need a blood lead test based on these risk/exposures to lead:**

- ☐ On public assistance
- ☐ In place built before 1978 or recently remodeled
- ☐ Knows someone with lead poisoning
- ☐ Pica behavior
- ☐ Someone in home works with lead
- ☐ Child given home remedies
- ☐ Child anemic
- ☐ Vinyl mini-blinds in home
- ☐ Uses old/imported pottery/dishes/candy
- ☐ Lived in another country
- ☐ Other_____

CHDP/Medi-cal Providers MUST: Test child at 1 **AND** 2 years of age.
Test child if 2-6 years and never been tested for lead.

Interviewer Name/Agency: _____ Date: _____

For more information on lead call: Sacramento County Childhood Illness & Injury Prevention Program (916) 875-5869
Follow-up letter given to parent. Date: _____

CALIFORNIA DEPARTMENT OF EDUCATION
CHILD DEVELOPMENT DIVISION
CD 9600A (NEW 1/00)

CHILD CARE DATA COLLECTION
PRIVACY NOTICE AND CONSENT FORM

The US Department of Health and Human Services (HHS) is gathering information about families that receive child care assistance. The information will be reported to the California Department of Education (CDE), and then to HHS. The information will be used for research on the status of child care in the United States, and will provide valuable data for those developing child care programs and policies at the state and local, as well as the national level.

All of the information HHS receives about your family and others will be summed up and reported to Congress every two years. No person or family will be individually identified in reports made to Congress or to the public. All information CDE receives about your family and others will be summed up, and no person or family will be individually identified in reports made to the Legislature, other governmental agencies or the public.

To ensure that children and families receiving child care services are counted only once, HHS and CDE are requesting the social security number of the head of the family unit receiving child care assistance. If you do no wish to give your social security number for this purpose, you may still receive child care assistance. Social security numbers will help us meet HHS reporting requests and state requirements for program statistics. Authority to ask for your social security number for this purpose is in Section 98.71(a)(13) of Title 45 of the Code of Federal Regulations, *Education Code* Section 8261.5, and Section 18070 of Title 5 of the California Code of Regulations. Your decision to provide your social security number is voluntary.

I have been informed of the way my social security number will be used.
I understand that if I do not wish to give my number, I can still receive
child care assistance.

- ❑ YES, my social security number may be used: _____ _____ _____
- ❑ NO, I do not wish to give my social security number for this purpose.

_____ _____
Signature of Head of Household Date

_____
Type of Print Name

If you would like a copy of this form, please ask.

You have the right to access records containing your personal information. For information about this system of records, contact the California Department of Education, Child Development Division, 1430 N Street, Sacramento, CA 95814; telephone (916) 445-1907.

Facing the Facts:
A Parent's Guide to the Understanding of *Child Abuse*

Definition of Child Abuse

As used in this article, "child abuse" means a physical injury which is inflicted by other than accidental means on a child by another person. "Child abuse" also means the sexual abuse of a child or any act or omission proscribed by Section 273a (willful cruelty of unjustifiable punishment of a child) or 273d (unlawful corporal punishment or injury.) "Child abuse" also means the neglect of a child or abuse in out-of-home care, as defined in this article. "Child abuse" does not mean a mutual affray between minors. Penal Code Section 11165.6

Definition of Sexual Abuse

As used in this article "sexual abuse" means sexual assault or sexual exploitation as defined in the following:
(a) "sexual assault" means conduct in violation of one or more of the following sections: Section 261 (rape), 264.1 (rape in concert), 285 (incest), 286 (sodomy), subdivision (a) or (b) of Section 288 (lewd or lascivious acts upon a child under 14 years of age), 288a (oral copulation), 289 (penetration of a genital or anal opening by a foreign object), or 647a (child molestation.) Penal Code Section 11165.1

Definition of Neglect

As used in this article, "neglect" means the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person Penal Code Section 11165.2

Contacts and Services

For your information, the following chart shows what agencies may assist you in the specific areas listed below:

	Police or Sheriff	County Dept of Children's Social Svc.	State or Local division of Community Care Licensing
If you believe a child is being (or has been) abused by an individual (relative, friend….)	✓	✓	
If you believe a child has been assaulted by a stranger…	✓		
If you believe a child is being (or has been) abused in a licensed day care setting (child care center, school, recreational facility, family day care home….	✓		✓
If you have any questions or complaints concerning the licensing organization, staffing, or programs of a licensed child care setting…		✓	

Mandated Reporters

While everyone should report suspected child abuse and neglect, the California Penal Code provides that certain professionals and lay persons must report suspected abuse to the proper authorities. These include:

- Any child care custodian (teacher, licensed day care workers, foster parents, social workers)
- Medical Practitiioners (physicians, dentists, psychologists, nurses)
- Non-medical Practitioners (public health employees, counselors, religious practitioners who treat children)
- Employees of a child protective agency (sheriff, probation officers, county welfare department employees)

If abuse is suspected a phone report to Police or CPS must be made immediately. Failure to submit the written report of suspected abuse by a mandated reporter (listed above) within 36 hours is a misdemeanor punishable by 6 months in jail and/or a $1000 fine.

Child Abuse Prevention Curriculum

With your permission, your child will participate in a developmental safety program.

Remember, you have the primary responsibility for your child's well-being. With a little time, effort and understanding you may prevent your child from being abused or assist your child when abuse has occurred.

Child Abuse Prevention Information Receipt

This will acknowledge that I/we, the parents of _____ have received a copy of
Child's Name

"Facing the Facts: A Parent's Guide to the Understanding of Child Abuse" from the _____
Name of Facitlity

Signature of Parent(s)/Guardian(s)_____ 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: _____

   Licensing Office Address: _____

   Licensing Office Telephone #: _____

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

(Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' R I G H T S

(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.

_____
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

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

River City Regional Office

ADDRESS

2525 Natomas Park Drive, Suite 250

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER	AREA CODE/FAX NUMBER
Sacramento	95834	(916) 263-5744	(916) 929-6371

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)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

Sacramento City Unified School District

CHILD DEVELOPMENT

Dear Volunteer,

We are pleased that you have decided to participate in the Sacramento City Unified School District (SCUSD) Child Development Volunteer Program! As parents, grandparents, neighbors and community members you have valuable ideas, talents and time to share with our students and our schools.

It is our belief that our volunteer programs are beneficial to everyone involved. Volunteers help foster stronger school/community relationships by creating a common ownership in the success of our schools, as well as, demonstrating the importance of community service to our students.

The SCUSD Child Development Volunteer Program provides support and guidance to schools to help them facilitate their parent and community engagement programs. Currently, volunteers work in a variety of capacities: doing work from home; providing assistance in the classroom; participating on partnership advisory boards and assisting on field trips, etc.

This packet includes:

- Volunteer Registration Process
- Volunteer Registration and Code of Conduct Form (maintained at site with a copy to Volunteer Office)
- Volunteer Sex Offender Check Authorization (SOC-1 Rev.3/2010) Level II

Upon request:

- Volunteer Rules and Regulations – Excerpted from Administrative Regulations (AR 1240) and School Board Policy (BP 1240)

Registration Process:
In order to start volunteering, you need to have the following items on file with your school:

1. A current and completed volunteer registration and code of conduct form.
2. Copy of a recent TB Test or chest x-ray form/ card indicating a negative result.
3. A completed and cleared Volunteer Sex Offender Check Authorization Form (SOC-1)
4. Vetted volunteers must meet with school staff to review volunteer Rules and Regulations and site policy and procedures. **The Child Development Department will also offer a volunteer training. Dates TBA.**

If you have any questions, please direct them to Rose Moya, Child Development Parent Advisor at (916) 643-7822.

Thank you,
Child Development
Sacramento City Unified School District

SCUSD CHILD DEVELOPMENT
Volunteer Registration & Code of Conduct Form

I. As a Volunteer, Your Role and Responsibilities in the Classroom Are Unique

- **Understand** that your role is a supportive one. The teacher is completely in charge. If the teacher leaves the room, you may not be left alone with children.
- **Maintain** student confidentially at all times. Do not discuss any student with anyone except teachers.
- **Report** immediately to a staff person any abuse towards a student.

II. Volunteers Take Pride in Being Professional

- **Maintain** a constructive attitude. Don't make negative comments about the school, its personnel or the students to other volunteers or individuals outside the school.
- **Keep** an accurate record of your attendance.
- **Dress** and act professionally.
- **Never** be under the influence of alcohol or illegal drugs with students on or off school grounds.
- **Do not** smoke on school grounds or at any time around students.
- **Do not** use the internet inappropriately by going to websites that are not conducive to a professional or educational environment.
- **Do not** use cellphone in the classroom or at any time around students.

III. Health and Safety Are Always Important

- **Adhere** to district, school and classroom policies rules and regulations.
- **Refer** any student in need of first aid or any type of medication to the teacher.
- **Learn** and follow fire drill emergency procedures and all classroom/school rules.
- **Notify** the Coordinator of any accident you had on school grounds. An accident report form must be submitted to the Coordinator within 24 hours.

I agree to adhere to the above code of conduct at all times when I am a volunteer at a SCUSD school site or program. I understand that my volunteer status can be revoked at any time.

Volunteer Signature_____ **Date**_____

VOLUNTEERS PERSONAL INFORMATION:

First Name _____ Last Name_____

Date of Birth month_____ day_____ year_____

Home Address _____City_____ Zip Code_____

Home Telephone (_____) _____Cell Telephone (_____) _____

School Where I Will Be Volunteering_____

Student Name (*if applicable*) _____ Teacher/Room # _____

Agency or Organization (*if applicable*) _____

In Case of Emergency Notify: (Name and Phone Number) _____

OFFICE USE ONLY

- ☐ **Verification of TB Clearance (Required)** Date of reading:_____
- ☐ **Sex Offender Clearance (Required)** Date cleared:_____
- ☐ **Parent Advisor Signature(Required)** Signature:_____

Instructions: This form is confidential.
Send original to Rose Moya, Child Development Parent Advisor
Do not retain copy.

VOLUNTEER SEX OFFENDER CHECK AUTHORIZATION
(SOC-1)

Required for VOLUNTEER LEVEL II

FOR CHILD DEVELOPMENT SITE/PROGRAM_____

SIGNATURE OF PRINCIPAL/SUPERVISOR Rose Moya, Child Development Parent Advisor
E-MAIL: moyar@scusd.edu Phone: 643-7822

IMPORTANT: This form is for **VOLUNTEERS UNDER THE DIRECT SUPERVISION** of SCUSD certificated staff. There is no charge to sites to cover the costs of conducting a Sex Offender Check. *If the prospective volunteer will be assigned to a project for which fingerprinting is mandatory, do not have them complete this form. You must complete a Background Check Authorization (form BC-1) and send them to the SCUSD Human Resources Office at the Serna Center to be fingerprinted. If you have questions about which level of screening is required for a specific volunteer, please call 643-7924.*

Prior to beginning any assignment, SCUSD Board policy requires that all volunteers be cleared to work by the Department of Justice.

- *I understand this requirement and will not volunteer with the district until clearance is received from the SCUSD Human Resources Office.*
- *I have received a copy of district rules and regulations for volunteers [BP1240 and AR 1240].* *Upon Request*
- *I hereby fully release and discharge the Sacramento City Unified School District, its officers, employees, agents and volunteers from any and all liability arising out of or in connection with this background check and all liabilities associated with and all claims related to this background check. For the purposes of this release, 'liability' means all claims, demands, losses, causes of action, suits or judgments of any and every kind that arise as a result of the above named activity and resulting from any cause other than gross negligence.*

Prospective Volunteer's Signature_____ **Date**_____

PLEASE PRINT NEATLY
Name (First/MI/Last) _____ Child's Name: _____

Other Names You have Been Known As: _____ Maiden Name_____

Date of Birth_____/_____/_____ Email ☐ Yes_____
Month Date Year May We Use This Email Account To Send Volunteer Updates?

Address _____ City _____ ZIP_____

Home Phone: _____ Cell phone: _____ Work: _____

A conviction may not necessarily disqualify you from the volunteer job for which you have applied. Convictions include diversionary offenses, or other offenses that have been plea-bargained, or for which you have pleaded no contest. **Failure to reveal convictions is grounds for immediate termination. Volunteer service may be terminated if service is unsatisfactory or no longer needed by the school district. District policy is available on the website: www.scusd.edu**

- Have you ever been convicted of a felony or misdemeanor? Yes____ No____
- If the answer is YES, please explain: _____

Confidential

Sacramento City Unified School District
CHILD DEVELOPMENT DEPARTMENT

FAMILY WORKSHEET

Check all that apply:
- ❑ HS Part Day
- ❑ State Preschool
- ❑ HS Wrap
- ❑ HS Home-based
- ❑ Children's Center

Child:_____Birth Date:_____ ☐M ☐F Site:_____ ☐AM ☐PM

Parent / Legal Guardian(s): _____, _____

Home Phone: _____ Other Phone: _____ English speaker: Yes ☐ No☐

If not, what language do you speak? _____ In what language do you prefer written material? _____

If you would like to receive information on a topic listed below, please check:

	Notes:		Notes:
☐ Counseling		☐ Food	
☐ Stress Management		☐ Clothing	
☐ Child Discipline		☐ Emergency Shelter	
☐ Substance Abuse		☐ Utilities	
☐ Child Abuse Prevention		☐ Transportation Referral	
☐ Child Support Assistance		☐ GED/High School Diploma	
☐ Incarcerated Parent Assistance		☐ Adult Education	
☐ Marriage Support Assistance		☐ College	
☐ Domestic Violence		☐ ESL *(English as a Second Language)*	
☐ Medical/Dental _____		☐ Job Training/Job Search	
☐ Other: _____		☐ Special Education	
☐ None of the above		☐ Other: _____	
		☐ None of the above	

In an effort to work cooperatively with other agencies, please check any services you are receiving.

☐ Medi-Cal	☐ Energy Program Assistance	☐ Family Preservation
☐ *TANF/Cal Works	☐ General Assistance	☐ Probation
☐ Food Stamps	☐ Child Support/Alimony	☐ Unemployment Insurance
☐ Public Housing Assistance	☐ SCOE	☐ Supplemental Security Income (SSI)
☐ WIC	☐ ALTA Regional Center	☐ Other: _____
		☐ None of the Above

☐ *Have you established a TANF goal? ☐Yes ☐No

What are your interests and strengths?

☐ Working with children	☐ Gardening	☐ Crafts
☐ Handy-work	☐ Sewing	☐ Music
☐ Painting	☐ First Aide	☐ Carpentry
☐ Planning/Organizing	☐ Storytelling	☐ Writing
☐ Cooking	☐ Security	☐ Photography
☐ Cosmetology	☐ Retail Services	☐ Other: _____
☐ Computers	☐ Typing	☐ None of the Above

Parent/Legal Guardian(s) Signature(s): _____/_____ Date: _____

I have received the "Community Resources" handout. ☐
Please Initial

For 1st Home Visit

I have reviewed the Family Worksheet with Teacher/School Community Liaison (SCL). _____
Parent's Initial and Date

Teacher/School Community Liaison (SCL)/Home visitor Signature: _____ **Date:** _____
Notes:

Distribution: White – Child's File Yellow – SCL / Central Support Staff Pink – Parent

Sacramento City Unified School District

CHILD DEVELOPMENT DEPARTMENT
5735 47th Avenue, Box 715 ● Sacramento, CA 95824
(916) 643-7800 ● FAX (916) 399-2057

Dear Parent/Guardian:

Tuberculosis is an infectious disease which is spread through the air when a person infected with active TB coughs, speaks, sings, sneezes or spits. The only way to know for certain if you have been infected with TB is to be tested by a medical professional. A test commonly used to detect TB is the PPD skin test.

The Head Start Program mandates all Head Start parents/guardians and other volunteers to have a TB clearance on file with the preschool office. This requirement applies whether or not you participate in the classroom.

Our records indicate that you do not have a TB clearance on file; therefore, you are required to obtain one now. If you have a history of a positive skin test, documentation from your doctor or clinic of a negative chest x-ray is needed.

Give the results of your TB screening to your assigned office technician for your child's center.

If you decline to obtain your TB clearance, the statement at the bottom of this letter must be signed.

- -

I understand that a TB clearance is required whether or not I participate in the classroom; however, I decline to obtain a TB test. I understand that by declining to obtain a TB clearance I am excluding myself from participating in my child's classroom.

______________________________ ______________________________
Parent/Guardian Signature Date

______________________________ ______________________________
Print Parent/Guardian Name Child's Name

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
CHILD DEVELOPMENT DEPARTMENT
PHYSICAL EXAMINATION REPORT OF STUDENT

ATTENTION PROVIDER AND PARENT/GUARDIAN:

Head Start mandates that a complete physical be given within one year prior to enrollment and annually. The CHDP and Head Start guidelines require a blood lead screen at 12 and 24 months. A recent Hemoglobin/Hematocrit is also required.
PLEASE DO NOT RETURN THIS FORM TO THE PARENT UNTIL THERE IS A NUMERICAL VALUE ENTERED FOR LEAD AND HEMOGLOBIN/HEMATOCRIT. Thank you.

NAME: _____ **BIRTHDAY:** _____ **PRESCHOOL:** _____

Parent's/Guardian's Authorization: I hereby give my consent to the school nurse and my physician to exchange information concerning my child.

PARENT'S/GUARDIAN'S SIGNATURE: _____ **PHONE:** _____ **DATE:** _____

EXAMINATION RESULTS	NORMAL	ABNORMAL	DESCRIBE FINDINGS/COMMENTS
HEIGHT: **WEIGHT:**			
GENERAL APPEARANCE, POSTURE AND GAIT			
HEAD / NECK			
SKIN			
MOUTH / TEETH			
SPEECH			
HEART / LUNG			
ABDOMEN (HERNIA)			
EYE: EXTERNAL			
ACUITY: RIGHT LEFT			**R20 /** _____ **L20 /** _____
EARS: EXTERNAL			
TYMPANIC MEMBRANES			
AUDIOMETRIC: RIGHT LEFT			**25 dB @ 1000-4000 Hz R**_____ **L**_____
GENITALIA			
BONES, JOINTS AND MUSCLES			
NEUROLOGICAL EXAM: REFLEXES, COORDINATION			
URINALYSIS			
LEAD TEST RESULTS (REQUIRED FOR PRESCHOOL)			_____ **ug/dl Date:**_____ Enter numerical value
BLOOD PRESSURE (REQUIRED FOR PRESCHOOL)			
HCT/OR HGB (REQUIRED FOR PRESCHOOL)			Enter numerical value. If anemic, is child receiving treatment?

TB RISK ASSESSMENT RESULTS> PPD INDICATED ☐YES ☐NO or PPD Date given _____Date read_____ Results_____

IMMUNIZATIONS GIVEN THIS VISIT:

☐ Polio	☐ DTP/DtaP	☐ MMR	☐ Hep B	☐ HIB
☐ Other (List):				
Next Shots Due/Date:				

Recommendations for physical activity: ACTIVE_____ LIMITED_____ Please specify :_____
Special Education Services: Speech Impairment_____ Developmental Delay_____ Behavior Disorder_____ Learning Disability_____ Physical Disability_____ Emotionally Disturbed_____
Any regular medication? NO_____ YES_____ Will medication need to be taken at school? If yes, please indicate _____
Are there indications that this pupil will need special help in adjusting to the school experience? _____

PLEASE NOTE ANY HEALTH CONCERNS THAT WILL AFFECT THIS CHILD'S PRESCHOOL EXPERIENCE

_____

PHYSICIAN NAME (PRINT) _____ **PHYSICIAN'S SIGNATURE** _____

MEDICAL GROUP NAME _____ **DATE OF EXAMINATION** _____

PHONE: _____

Revised 6/17/11

CHILD DEVELOPMENT DEPARTMENT
5735 47th Avenue, BOX 715 • Sacramento, CA 95824
(916) 643-7800 • FAX (916) 399-2057

DENTAL HEALTH RECORD

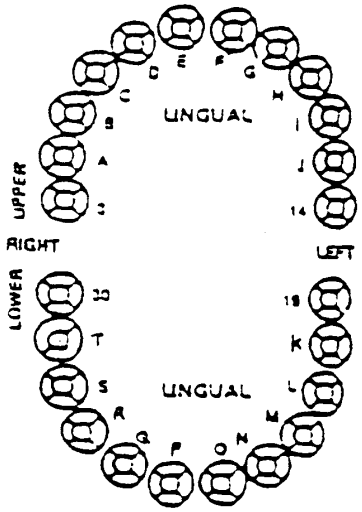
Child's Name: _____ Birthdate: _____ M___ F___ Preschool: _____

Parent/Guardian Name: _____ Phone: _____

Address: _____

I authorize professionally qualified people to exchange information about my child. I understand that all information will be kept in a confidential file.

Parent/Guardian Signature: _____ Date: _____



PLEASE LIST ALL SERVICES RECEIVED BELOW:

Date of Service	Description of Service

- ☐ Dental exam completed
- ☐ Preventive dental care completed
- ☐ Incomplete, further restorative TX needed
  Approximate number of visits needed _____
- ☐ Treatment in process
- ☐ Treatment completed

DATE OF NEXT DENTAL VISIT_____

If treatment is not complete at this visit, please fill out a new form for each additional visit until treatment is completed. Please return completed forms to: (PLEASE CHECK ONE)

☐ Child Development Department
Capital City Registration Center
7220 - 24th Street, Sacramento, CA 95822
(916) 433-2736 **Fax: (916) 433-2738**

☐ Child Development Department
Hiram Johnson Family Education Center
3535 65TH Street, Sacramento, CA 95820
(916) 277-7157 **Fax: (916) 277-6698**

Dentist: _____ _____ _____
(Please print) (Signature) (Date)

Address: _____ Phone: _____