



SKYLARK PRESCHOOL
11250 MAC MURRAY STREET
GARDEN GROVE, CA 92841
PH. (714)663-6336 FAX (714)663-6135

Garden Grove Unified School District Preschool Programs

Student Name: _____ DOB: _____

From Parent:

- Original Birth Certificate
- Immunizations Record
- Parent/Guardian Photo I.D.

Licensing Documents:

- Emergency Information
- Physician's Report- **(Form & TB box must be completed by Physician)**
- Health Screening Form
- Insurance Questionnaire
- Student Health History (If student has IEP, please provide copy)
- Photo/Media/Website Release
- Parent's Rights
- Personal Rights
- Acknowledgement of Parent Handbook (handbook will be given at registration appointment)

Other Documents (at time of registration appointment):

- Visual Dental Screening Form
- ASQ Questionnaire (Must be completed after July 1st <https://www.asqonline.com/family/c1903d?single=true>)
- Enrollment Contract
- Fee Schedule
- \$100 registration Fee- Check or Money order payable to GGUSD (fee not exceed \$150 per family)

Parent Participation:

- Flyer: Value of Being a Volunteer
- Volunteer Information Form
- Immunizations Requirements and Guidelines



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<u>Office Use Only</u>	
Health Alert:	_____
Photo/Media:	_____
Emergency Treatment:	_____
Restraining/ Custody:	_____

REGISTRATION & EMERGENCY INFORMATION

Student Name (Last, First, Middle): _____ Birth Date: _____ Sex: _____

Home Address, City, Zip: _____

Parent 1 (Full Name): _____

Home Phone: _____ Cell Phone: _____ E-mail Address: _____

Employer: _____ Work Phone: _____ Ext: _____

Parent 2 (Full Name): _____

Home Phone: _____ Cell Phone: _____ E-Mail Address: _____

Employer: _____ Work Phone: _____ Ext: _____

Restraining/ Custody Order – Do you have a Restraining Order/ Custody Order on file with the courts? Yes No

Name(s) of any person who is restrained **by court order** from picking up student: _____

A **certified copy of the court order must be on file at the school. In the absence of a court order indicating otherwise, either natural parent may have access to remove a student from school.*

A copy of the **current custody court order **must be on file in the school office** to deny a natural parent access to his/her child.*

Name of persons authorized to pick up your child from the facility

Note: Persons authorized to pick up your child MUST have picture I.D. and be at least 18 years of age.

Name _____ Relationship _____ Phone # _____ Language _____

Name _____ Relationship _____ Phone # _____ Language _____

Name _____ Relationship _____ Phone # _____ Language _____

Emergency Medical Treatment – Do you give approval for the named student to receive emergency medical treatment if the student’s parent/guardian cannot be contacted? Yes No

Health History/ Information:

Please give us any medical or developmental information about your child that may assist us in meeting his/ her needs.

List any/all medications your child is currently taking: _____

Allergies: _____

Doctor’s Name and Phone #: _____

Signature _____

Date _____

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)
Garden Grove Unified School District . This Child Care Center/School provides a program which extends from 08 : 00
(NAME OF CHILD CARE CENTER/SCHOOL)
a.m./p.m. to 3:00 a.m./p.m., 5 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

RISK FACTORS FOR TB IN CHILDREN:

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

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



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Parent Consent for Health Screening

Dear Parents/Guardians of Preschool Children:

Garden Grove Unified School District is providing free services through the School Readiness Program. The screenings provided enable the School Readiness nurse to identify children who are in need of special medical intervention. Your written consent is required for any of these available screenings.

The following screenings and services will be provided throughout the school year:

- Hearing
- Vision
- Dental
- Health and Nutrition
- Developmental
- Height, Weight, and Body Mass Index

With my signature below, I give my consent for the screenings listed above. I understand that I will be provided with a written result from any screening that requires a medical referral. I also give my permission for the nurse to share with the teacher any screening results that may have an impact on my child's safety and/or learning.

Student's Name: _____
Last Name, First Name Middle Name

School Site: _____ Room #: _____

Signature of Parent/Guardian

Date

The School Readiness nurses are available to assist you in obtaining health insurance and/or community services. For further information, please contact:

**Clinton Corner Family Campus
 School Readiness Nurses
 Tel: (714) 663-6298**





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Insurance Questionnaire

Parent Name: _____ Phone Number: _____

Child's Name: _____ School: _____ Room # _____ AM/PM

1. Does your child have medical insurance? ___yes ___no

Please check below what kind of insurance your child has:

Medi-Cal Private medical insurance Other: _____

If your child has no insurance, would you like help applying for Medi-Cal? ___yes ___no

2. Does your child have dental insurance? ___yes ___no

3. Does your child have a doctor/pediatrician? ___yes ___no

4. Is your child receiving any services from Garden Grove Unified School District, such as speech therapy, special education, etc.? ___yes ___no

Nombre de padre: _____ Número de teléfono: _____

Nombre del niño(a): _____ Escuela: _____ N° del salón: _____ AM/PM

1. Tiene su niño(a) seguro médico? ___sí ___no

Por favor marque la clase de aseguranza medica que tiene su niño(a).

Medi-Cal Aseguranza Privada Otra: _____

¿Si su niño(a) no tiene ningún seguro, quisiera usted ayuda para aplicar para Medi-Cal? ___ sí ___ no

2. ¿Tiene su niño(a) aseguranza para el dentista? ___ sí ___ no

3. ¿Tiene su niño(a) un doctor/pediatra? ___ sí ___ no

4. ¿Recibe su niño(a) algunos servicios del Distrito Escolar de Garden Grove, como terapia para el habla/language, educación especial, etc.? ___ sí ___ no

Tên của phụ huynh: _____ Số Điện Thoại: _____

Tên Học Sinh: _____ Trường _____ Phòng # _____ AM/PM

1. Con em của quý vị có bảo hiểm sức khỏe không? ___Có ___Không

Vui lòng đánh dấu loại bảo hiểm mà con em quý vị đang có

Medi-Cal Bảo hiểm tư Loại khác: _____

Nếu con của quý vị không có bảo hiểm sức khỏe, quý vị có muốn được giúp đỡ điền đơn xin MediCal không? ___Có ___không

2. Con em của quý vị có bảo hiểm nha khoa không? ___Có ___Không

3. Con em của quý vị có bác sĩ gia đình không? ___Có ___Không

4. Con em của quý vị có nhận những dịch vụ giáo dục đặc biệt từ Khu Học Chánh Garden Grove không?

Ví dụ, chương trình tập nói, hay chương trình giáo dục đặc biệt nào, v.v? ___Có ___Không



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Student Health History

To assist school personnel to better meet the health needs of your child, please complete the following form. Medication at school, prescription or non-prescription, requires doctor's orders, parent signature and must be kept in the office unless doctor permits otherwise. Please request required form from school staff.

Student's full name: _____

Date of birth: ____/____/____ **Place of birth:** _____ Male Female

Pediatrician/ Family Doctor: _____ **Dr. Off. Tel#:** _____

Last date of Physical Exam: ____/____/____

Does the student receive any outside services? Yes No Does the student have an IEP? Yes No

If yes, please check appropriate box: Speech Special Education Other: _____

Are health conditions present? Yes No **If yes, check any health conditions listed below that your child has had within the past year. If additional space is needed use space at bottom of page.**

1. Vision impairment: Glasses or Contacts Others _____
2. Allergy: Food _____ Medication _____
 What symptoms does your child get from allergen? _____
 Need medication at school? Yes No Need Epi-pen? Yes No
3. Attention Deficit Disorder. Medication _____ Required at school? Yes No
4. Asthma: List medications _____ Required at school? Yes No
5. Diabetes: Medication or blood testing requires at school? Yes No
6. Epilepsy/seizure disorder: Medication _____ Required at school? Yes No
7. Hearing lost: Right ear Left ear Hearing aids? Right ear Left ear
8. Heart condition. Type? _____ Activity restriction? Yes No
9. Arthritis, Osgood Schlatter Disease or other bone joint disorder? Affect PE activity? Yes No
10. Migraine headaches? Medication _____ Required at school? Yes No

The health conditions listed below may require further information and/or discussion with the school nurse

- Kidney or bladder problem. Please explain _____
- Blood disorder. What kind? _____
- Cancer. What kind? _____
- Cerebral Palsy? Any limitations? _____
- Cystic Fibrosis. Medications _____ Required at school? Yes No
- Eating disorder. What kind? _____
- Endocrine disorder. What kind? _____
- Neurological condition. What kind? _____
- Emotional/Psychiatric disorder. Medication _____ Required at school? Yes No
- Any hospitalizations or surgeries? Reason: _____ Date _____
- Other _____

Additional comments or explanations regarding any condition or "yes" checked above _____

*** I request and authorize _____ to release healthcare information of the student named above to Garden Grove Unified School District State Preschool Program

Parent/Guardian Name

Parent/Guardian Signature

Date



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Photo / Media / Website Release

The Garden Grove Unified School District is known for its outstanding and talented students and, from time to time, the district receives requests from the news media to photograph students for positive public relations. Because such photo requests often require an immediate response, we are asking your permission for the entire school year rather than on an individual basis.

Students who have achieved success in school should be acknowledged, and news media coverage is one means available for that purpose. This district may also want to use student photos, identified by their name and school, for publications - including press releases, district and school newsletters, and district and school websites.

Please complete and sign in the section below.

- I grant permission for the Garden Grove Unified School District and the school to have my child's photograph taken for use by the media, in district and school publications (yearbooks included), and in district and school websites.
- I deny permission for the Garden Grove Unified School District and the school to have my child's photograph taken for use by the media, in district and school publications (yearbooks excluded), and in the district and school websites.

Student's Name: _____
Last Name, First Name Middle Name

School Site: _____ Room #: _____

Signature of Parent/Guardian

Date

CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: Community Care Licensing

Licensing Office Address: 750 The City Drive, Suite 250, Orange, CA 92868

Licensing Office Telephone #: (714) 703-2800

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender" database, go to www.meganslaw.ca.gov

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS (Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of (Student Name), have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Garden Grove Unified School District
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:

Department Of Social Services

NAME

Community Care Licensing

ADDRESS

750 The City Drive, Suite 250, MS 29-10

CITY

Orange, CA

ZIP CODE

92868

AREA CODE/TELEPHONE NUMBER

(714) 703-2800

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)

Garden Grove Unified School District

(PRINT THE ADDRESS OF THE FACILITY)

10331 Stanford Ave. Garden Grove., CA, 92840

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

Parent/ Guardian

(DATE)



**Skylark Preschool
Garden Grove Unified School District**

**Parent Handbook
Acknowledgement of Receipt of Handbook**

I acknowledge receipt of Garden Grove Unified School District's Preschool Parent Handbook. I have reviewed and agreed to comply with the policies and procedures stated within.

Student Name

Date

Parent Name

Parent Signature



The Value of Being a Volunteer in the Classroom

El Valor de Ser un Voluntario en el Salón

Giá trị của việc làm tình nguyện trong lớp học



Children are proud to have their parent in the classroom.
Los niños están orgullosos de tener a sus padres en el salón.
Em nhỏ sẽ rất hạnh phúc khi có Cha Mẹ trong lớp của mình.



Parents learn new ways to teach and manage behavior.
Los padres aprenden nuevas formas de enseñar y manejar el comportamiento.
Phụ huynh sẽ học hỏi được những phương cách mới trong việc dạy dỗ và chăm sóc em nhỏ.



Parent volunteers mean so much to teachers.
Los padres voluntarios significan tanto a las maestras.
Cô giáo rất cần phụ huynh đến lớp giúp.



Parents can connect with other parents.
Los padres pueden conectarse con otros padres.
Phụ huynh có dịp giao tiếp với những phụ huynh khác.



Parents help children learn.
Los padres ayudan a los niños aprender.
Phụ huynh giúp con em mình học tập tốt hơn.



Parents help monitor children.
Los padres ayudan a vigilar a los niños.
Phụ huynh giúp trông chừng các học sinh trong lớp.



Parents help their children at home with what they learn at school.
Padres ayudan a sus hijos en casa con lo que han aprendido en la escuela.
Tại nhà, phụ huynh giúp con em ôn tập những gì chúng đã học ở trường.



It's Fun!
¡Es divertido!
Rất vui!



Parent shows child that school is important.
Los padres muestran a los niños que la escuela es importante.
Phụ huynh chứng tỏ cho con em thấy rằng việc học rất quan trọng.

GARDEN GROVE UNIFIED SCHOOL DISTRICT
Office of Personnel Services
Volunteer Information Form

<input type="checkbox"/> ML	<input type="checkbox"/> TB	<input type="checkbox"/> TDAP	<input type="checkbox"/> MMR	<input type="checkbox"/> FLU
Admin: _____				

Student's Name: _____ School: _____ Room#: _____ AM / PM
Last Name, First Name Middle Name

Volunteer's Name: _____ Volunteer Date of Birth: _____ DL/ ID #: _____
Last Name, First Name Middle Name

Address: _____ Apt/ Spc: _____ City: _____ Zip Code: _____

Phone () _____ () _____ () _____
Home Cell Work Ext.

Examples of Volunteer Duties: Interact with students during meal times and small groups, assist teachers with a variety of activities, and supervise children throughout the day.

Have you ever been convicted of: A felony? Yes: _____ No: _____
 Any sex or drug offense? Yes: _____ No: _____

If yes briefly describe including date(s) _____

In the event of an emergency, do you have any health problems we should be aware of? _____
 Please list names and telephone number of an individual to be contacted in the event of an emergency while you are rendering volunteer services:

_____	_____	_____
Full Name	Relationship	Phone
_____	_____	
Doctor	Phone	

Please list names and telephone numbers of your current and previous employer:

_____	_____	_____
Full Name	Phone	Dates of employment
_____	_____	_____
Full Name	Phone	Dates of employment

Please list two individuals who can serve as character references:

_____	_____	_____
Full Name	Relationship	Phone
_____	_____	_____
Full Name	Relationship	Phone

I understand that volunteers are not compensated and that my volunteer services are at the discretion of the Board of Education through its designee, the site principal, and that my services may be terminated at any time.

I understand that the district reserves the right to check my record with the Department of Criminal Justice, pursuant to Penal Code, Section 290.

Please excuse yourself from volunteering if you are not free from any communicable diseases which could readily be transmitted in a school environment, such as, but not limited to tuberculosis, hepatitis, etc.

I certify that all statements and information provided here in are true and complete to the best of my knowledge and belief.

Signature _____ **Date** _____

GARDEN GROVE UNIFIED SCHOOL DISTRICT
Office of Personnel Services

PROCEDURES FOR VOLUNTEERS

1. A volunteer is defined, as any person not employed by the school district that assists at a school on a regular basis.
2. Have the volunteer complete and sign the "Volunteer Information Form." **The completed form is to be kept in a confidential file at the school site.**
3. By law, all Garden Grove Unified School District volunteers are screened for tuberculosis. Volunteers may avail themselves of the reduced tuberculosis-screening fee offered to regular employees. Please find the name and address of the facility attached. **The results of the screening should be kept at the school site in a confidential file.**
4. **Complete the "Volunteer Penal Code Information Form" and send it to the Office of Personnel Services.**
5. The enclosed forms and information sheet should be copied as needed.

Encl: Volunteer Information Form
Volunteer Penal Code Information Form
Tuberculosis Testing Information Sheet



Volunteer Requirements and Guidelines

1. _____ Tuberculosis Skin Test (TB) Please submit one of the following

- Documentation of a negative TB test (Good for 2 years) or chest X-ray (good for 4 years)
- A statement from the volunteer's physician that there is a medical reason not to vaccinate the volunteer

2. _____ Measles Vaccine (MMR) Please submit one of the following

- A copy of immunization records for Measles (Good for Lifetime)
- A statement from the volunteer's physician that there is a medical reason not to vaccinate the volunteer
- A statement from the volunteer's physician that the volunteer is already immune to measles

3. _____ Pertussis Vaccine (TDAP) Please submit one of the following

- A copy of immunization records for Pertussis (Good for 10 years)
- A statement from the volunteer's physician that there is a medical reason not to vaccinate the volunteer

4. _____ Influenza Vaccine (FLU) Please submit one of the following

- A copy of an immunization record for influenza dated between August 1st and December 1st of each year, or
- A signed statement from the volunteer stating that they have declined to be vaccinated against the flu (SLIP BELOW)

Clinic Suggestions

For TB Test



MemorialCare Medical Group

15464 Goldenwest St.
Westminster, CA 92683
(714) 891-9008

- This clinic is open 7 days a week and Mantoux skin test (TB) can be given during that time.
- The office hours are 8:00 am to 8:00 p.m.
- You **MUST** return to the clinic **48 hours** later for the results of your test.

Cost:

TB..... approx. \$20.00 or more
X Rays..... approx. \$51.00

For Other Immunizations

Santa Ana Clinic

1725 W 17th St.
Santa Ana, Ca 90621
1(800) 914-4887 or 1(800) 564-8448



- Immunization Hours:
Mon _ Fri 7:30 -10:00am & 12:45 – 3:00pm
Walk-In Clinic: First come first served

If you do not have medical insurance the cost is:

MMR..... approx. \$18.50
TDAP..... approx. \$18.50
Free Flu Shot.....available annually Nov. – Mar.

Volunteer Immunization Documentation

To Whom It May Concern:

I am declining to be vaccinated against the flu at this time.

Volunteer Name: _____ Student's Name: _____
Last Name, First Name Middle Name Last Name, First Name Middle Name

Signature: _____ Date: _____

School: _____ Room: _____