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
- □ Toileting Contract (if applicable)
- □ 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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REGISTRATION & EMERGENCY INFORMATION

Office Use Only
Health Alert:____________
Photo/Media:____________
Emergency Treatment:_____
Restraining/ Custody:______

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**: ________

Preferred schedule, check one (current fees may be subject to change): ☐ **2 day (T,TH)** ☐ **3 day (M,W,F)** ☐ **5 day (M-F)**

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: ____

Food Restrictions: ______________________________ **Medical** ☐ **Religious** ☐

(If food restrictions are medically based, our health assistant will reach out to you for additional paperwork.)

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)	/ /	/ /			
HIB MENINGITIS (HAEMOPHILUS B) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	
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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11250 Mac Murray Street
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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:**_______________ **Nº 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/lenguage, educación especial, etc.? ___ sí ___ no

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Tên của phụ huynh:__________________________ **Số Điện Thoại:**____________________

Tên Học Sinh:___________________________ **Trường** ________________ **Phòng #**______**AM/PM**

1. Con em của quý vị có bảo hiểm sức khoẻ 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

Funded by: Children & Families Commission of Orange County

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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 ❑
   Food Restrictions:____ ☐Medical ☐ Religious
   If food restrictions are medically based, our health assistant will reach out to you for additional paperwork.
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	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Orange, CA	92868	(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)	(PRINT THE ADDRESS OF THE FACILITY)
Garden Grove Unified School District	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)	(DATE)
Parent/ Guardian	

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**