RIALTO UNIFIED SCHOOL DISTRICT

District Enrollment Center

[redacted]

Qualification for State Preschool is income based. Rialto U.S.D. offers preschool programs for those families who do not qualify based on their income. ** Space is limited.

Please provide the following documentation:

- ☐ Verification of income for each working parent in the home (income for the last 30 days)
- ☐ [redacted]
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

Onl com lete ackets will be acce

[redacted] PRESCHOOL

Notes:

[redacted]

Grade:

Date:

Student #:

School of Residence:

FAMILY INFORMATION (If there is a custody/restraining order for your child, please provide copy)

School Assigned:

□ Colton □ Other

Mailing address, if different Apt./Space □ Rialto □ San Bernardino Fontana Zip Code
□ Colton □ Other

Start Date:

Name of Legal Mother
Primary Phone Number Date of Birth Sex Preferred Language of Correspondence
Male □ Female

Name of Legal Father

Teacher:

Classroom/AM or PM:

CHILDREN LIVING UNDER YOUR CARE

Name	Date of Birth	School
Name	Date of Birth	School
Name	Date of Birth	School

Birth Verification: _____

P.O.B:

Enter Code:

PREVIOUS SCHOOL INFORMATION (List last school first)

Name of School	City	State	Grade	School Year
Has the student attended a Rialto USD school?	If yes, name school:		Grade	School Year

Address Verification:
□ Utility/Rent Receipt

[redacted]

PARENT EDUCATION LEVEL PRIOR SPECIAL EDUCATION PROGRAMS

[redacted]

Parent/Guardian Signature:

Housing Questionnaire

The information provided below will help your child's school to determine whether you and/or your child may be eligible for specialized services and supports. This could include additional educational services through Title I, Part A and/or the federal McKinney-Vento Assistance Act. The information provided on this form will be kept confidential and only shared

None of the above.

with appropriate school district and site staff

Student Name **Date of Birth**

School Assigned **Grade**

Which of the following describes you and/or your family's current living situation? *Please check all that apply.*

RIALTO UNIFIED SCHOOL DISTRICT
EARLY EDUCATION

260 South Willow Avenue, Rialto CA 92376
(909) 873-4300 Fax: (909) 873-4301

Authorization to Release Information (Parent 1)

I, (Employee Name), parent of (Student's Name) give authorization for

[redacted]

Name of Employer Contact Person

Employer/ Work Address City State Zip code

Employer Phone

[redacted] Job Title

Pay Schedule: ❒ Weekly ❒ Bi-Weekly ❒ Twice a Month ❒ Monthly **Gross Salary (Per Pay Period) $**

Note if flexible schedule: Hourly Rate $ Minimum hours per week_____ Maximum hours per week_____

I affirm that, to the best of my knowledge, the above information is true and correct:

SIGNATURE OF EMPLOYER DATE

OFFICE USE ONLY

Information obtained by:

☐	Telephone	Phone No:	Name:
☐	Facsimile	Fax No:	Name:
☐	E-Mai/ U.S.Mail		Name:

Notes:

Date: Verified by:

RIALTO UNIFIED SCHOOL DISTRICT
EARLY EDUCATION
260 South Willow Avenue, Rialto CA 92376
(909) 873-4300 Fax: (909) 873-4301

Self-Certification of Unemployed

I am currently:

- ☐ Seeking employment (Not receiving unemployment benefits)
- ☐ Stay at home Mom or Dad
- ☐ Full or Part time student
- ☐ Other (brief explanation):

I, _____ , swear under penalty of perjury, to the
(Parent Name)

best of my knowledge, that the information is true and correct.

Signature _____ Date _____

RIALTO UNIFIED SCHOOL DISTRICT
EARLY EDUCATION
260 South Willow Avenue, Rialto, CA 92376
(909) 873-4300 Fax: (909) 873-4301

Applicants for Early Education Preschool Programs

[redacted]

Parent / Applicant's Name

Student Name

[redacted]

Student Name: _____

Rialto Unified School District

Custody Issues

Parent Disputes over Custody in School Setting

[redacted]

Parent/Guardian Signature 1 Date

Parent/Guardian Signature 2 Date

Office use only:

Date Received: Home School:

Notification placed on Synergy: _____ Document(s) uploaded to Synergy: _____

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME | SEX | BIRTH DATE

FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME | DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?

[redacted]

WHEN?* | HOW LONG?*

WHAT ARE USUAL EATING HOURS?
BREAKFAST
LUNCH
DINNER

ANY FOOD DISLIKES?

IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?	WHAT IS USUAL TIME?
☐ YES ☐ NO		☐ YES ☐ NO	

WORD USED FOR "BOWEL MOVEMENT"*

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
☐ YES ☐ NO		☐ YES ☐ NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
☐ YES ☐ NO		☐ YES ☐ NO	

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT [redacted]

PARENT'S SIGNATURE | DATE

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

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

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

[redacted]

1. Enter and inspect the child care center without advance notice whenever children are in care

[redacted]

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office

[redacted]

Signature (Parent/Authorized Representative) Date

[redacted]

RIALTO UNIFIED SCHOOL DISTRICT
EARLY EDUCATION
260 South Willow Avenue, Rialto CA 92376
(909) 873-4300 Fax: (909) 873-4301

Child's Name **D.O.B** **Site**

(Please initial next to each statement)

[redacted]

PERSONAL RIGHTS
____ 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.

PARENT'S RIGHTS
____ I/We have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENT'S RIGHTS" form from the licensee.

PARENT PARTICIPATION
I understand a parent representing my child is encouraged to participate in the preschool program each month

[redacted]

RIALTO UNIFIED SCHOOL DISTRICT
HEALTH SERVICES
815 S. Willow Ave., Rialto, CA 92376 • Tel (909) 820-8150 • Fax (909) 820-8151

STUDENT HEALTH HISTORY

Student Name: **Date of Birth:** **Grade:**

☐ **My child does NOT have any known health conditions**

☐ **My child has the following health conditions:**
(check all that apply **and** if medication or treatment is required at school)

	Medication / Treatment RE UIRED at school
☐ Allergies Type of allergy: Type of Medication:	☐ Yes ☐ No
☐ ADHD / ADD	☐ Yes ☐ No
☐ Asthma	☐ Yes ☐ No
☐ Autism	☐ Yes ☐ No
☐ Birth Defects / Genetic Disorders	☐ Yes ☐ No
☐ Blood / Bleeding Disorders	☐ Yes ☐ No
☐ Hearing Loss	☐ Yes ☐ No
☐ Kidney Disorder / Bladder Problems	☐ Yes ☐ No
☐ Psychological Problems	☐ Yes ☐ No
☐ Serious accidents or hospitalizations	☐ Yes ☐ No
☐ Vision Impairment	☐ Yes ☐ No
☐ **Cancer / Leukemia**	☐ Yes ☐ No
☐ **Cerebral Palsy** ☐ ☐ ☐	☐ Yes ☐ No
☐ **Colostomy Bag** ☐ ☐	☐ Yes ☐ No
☐ **Diabetes:** ☐ **Type 1** **Type 2 – Insulin Dependent:** Yes No **If applicable:** ☐ Dexcom Insulin Pump Metformin ☐ Humalog Insulin Pen	☐ Yes ☐ No
☐ **Epilepsy / Seizures –** Requires Diastat	☐ Yes ☐ No
☐ **Gastrostomy Tube (G-Tube) –** ☐ Requires G-Tube feeding	☐ Yes ☐ No
☐ **Heart Problems / Heart Surgery**	☐ Yes ☐ No
☐ **Tracheostomy** ☐ Requires Suctioning Ventilator Dependent ☐ Oxygen Dependent	☐ Yes ☐ No
Other:	☐ Yes ☐ No

Special Treatments and/or Medications:

Parent/Guardian Signature: **Date:**

OFFICE USE ONLY

Emailed Health Services: Verified by Health Services: School:

[redacted]

NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

[redacted]

DATE

[redacted]

HOME ADDRESS

HOME PHONE

( )

WORK PHONE

( )

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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

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

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

[redacted]

PART B – PHYSICIAN'S REPORT TO BE COMPLETED BY PHYSICIAN

Problems of which you should be aware:

Hearing:

Vision:

Developmental:

Language/Speech:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

Allergies: medicine:

Insect stings:

Food:

Asthma:

MEDICATION PRESCRIBED SPECIAL ROUTINES RESTRI TI N FOR THI HILD:

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)	/ /	/ /	/ /	/ /	/ /
[redacted]					

[redacted]

Required for Pre-Kindergarten (Child Care)

CDPH

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

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

DTaP = di htheria toxoid tetanus toxoid and acellular ertussis vaccine

Hep B = he atitis B vaccine

Varicella = chicken ox vaccine

Hib = Haemo hilus influenzae t e B vaccine

MMR = measles mumps, and rubella vaccine

Free or Low Cost Health Coverage Exists for ALL Lower-Income California Families (options on page 2)

CALIFORNIA Information for other states is different.

Enroll.

Ways to enroll in Medi-Cal and Covered California:

- *1(800) 300-1506*
- *www.coveredca.com*
- **In-person:** *dhcs.ca.gov/COL*
- **Apply by mail:** Medi-Cal printable applications here: *www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/SingleStreamApps.aspx*
- **Find Help in Your Community:** Scan the QR code below or go to: *allinforhealth.org/HealthCoverageResources* to locate help near you

enew Your Co e age in ~3-24!

Get Care.

IMPORTANT for 2023 and 2024:

How to Renew your Medi-Cal Coverage and Report Changes:

What to Do to Stay Covered:

What if You No Longer Qualify for Medi-Cal Coverage?

health plan for help locating an available doctor near you

CONTINUOUS MEDI-CAL COVERAGE

Renew.

DHCS

PROTECTIONS END STARTING APRIL 2023.

Set up an account online.

Schedule an annual checkup for you and your child(ren). Young children need

FOR

COVERED CALIFORNIA

Scan this QR code for LOCAL HELP in your area.

OR GO TO:
www.allinforhealth.org

The Children's

Options for Health Coverage

I...migrant amilies

Medi-Cal:

Expansion of Medi-Cal

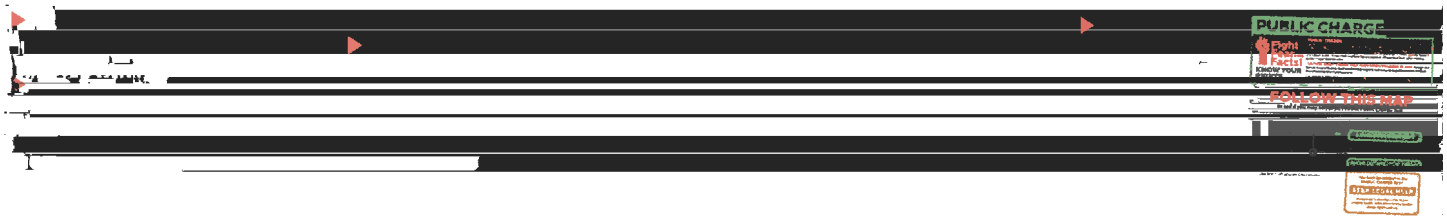
Updated Public Charge Rule

Covered California:

For more information about

Currently, every income-eligible

health care options regardless of immigration status



Covered California

Financial Help. You or your family may qualify for free Medi-Cal or premium assistance under Covered California.

% FPL	100%	138%	150%	200%	213%	250%	266	300%	322%	400%
	$13,590	$18,755	$20,385	$27,180	$28,947	$33,975	$36,150	$40,770	$43,760	$54,360
	$23,030	$31,782	$34,545	$46,060	$49,054	$57,575	$61,260	$69,090	$74,157	$92,120

Medi-Cal for Adults | Pre nant & s | iduals | Medi-Cal Access for Pregnant & Postpartum Individ

Medi-Cal for Kids (0–18 Yrs.) | CCHIP***

FOR ALL

A PROJECT OF The Children's

OUR PARTNERS:

MetroLA

para los niños for the children

FOR MORE INFORMATION GO TO: www.allinforhealth.org

ENTAL CARE

MED AL CARE

MED CAL CA E...*continued*

SSOCIATES
, Rialto

TY HEALTH CENTER
#A-2, Fontana

ISIO EXAMS

OMETRIC CENTER
Ne., Ste. 22
344

CENTER
Ne., Ste. 21
230

C CENTER
5
044

NSELING SERVICES

SERVICES
.
358

MUNITY SERVICES
Ste. 100, Colton

DINO COUNTY -
AL ASSISTANCE DEPARTMENT
thill Blvd., Rialto (877) 410-8829