LOS ANGELES UNIFIED SCHOOL DISTRICT
Early Childhood Education
TOLUCA LAKE CSPP
4840 Cahuenga Blvd., North Hollywood, CA 91601
Tel: (818) 761-3339 Fax: (818) 761-7197

This document should be included in the family file.

PARENT ENROLLMENT PACKET CHECKLIST

Dear: _____ Date: _____

Welcome to our Early Education Center. In order to enroll your child, please have available and completed by your appointment date, the documents & information checked below:

		(LAUSD SECTION) Received COMPLETE	Scanned to EESIS
☐	Birth Certificate or Baptismal Record of **ALL** children under 18 years of age in the family.	☐	☐
☐	Immunization records for child being enrolled (California Immunization Requirements for Child Care)	☐	☐
☐	Proof of income – One full month's worth of check stubs for the **prior** month for each parent employed. (If paid weekly, submit the last 4 **consecutive** check stubs, if paid bi-weekly, submit the last 2 **consecutive** check stubs.)	☐	☐
☐	Verification of TANF or other cash assistance (copy of most recent check – **prior month**, Notice of Action or Cash Issuance Receipt)	☐	☐
☐	Verification of residency (CA ID, CA Driver's License, Current Utility Bill, Rent Receipt, Lease Agreement, etc.)	☐	☐
	ATTACHMENTS		
☐	Home Language Survey	☐	☐
☐	Health History Card (white, to be completed by the parent/guardian)	☐	
☐	Physical Exam – Physician's Report (LIC 701 form to be completed by the doctor. Must be within the last 12 months and include screening of TB risk)	☐	
☐	Verification of Employment and Salary – Form 83.56	☐	☐
☐	Self-Certification of Income (if applicable)	☐	☐
☐	Verification of Training – Form EESD 9605 (Progress Report at Recertification Time) • **Request for study time must be written** and provided by parent	☐	☐
☐	Statement of Incapacity – CD 9606	☐	☐
☐	Child Protective Services Referral Form 83.66	☐	☐
☐	Seeking Employment Agreement	☐	☐
☐	Los Angeles Unified School District Parent Handbook – Forms completed & signed	☐	
☐	Emergency Information Card (At least 3 names, addresses and telephone numbers of persons, 18 years or older, authorized to pick up your child in case of emergency or illness) Make sure that the name matches what appears on Driver License or I.D.s	☐	
☐	If Applicable: Verification of Other Care Providers – Form 84.26	☐	
☐	Student Residency Questionnaire & Migrant Education Program Questionnaire	☐	
	Other : _____	☐	

Your appointment date is _____ **Time:** _____

You must bring all requested documents on that date, and be ready to stay 30 minutes, so that we can verify the information and give you the policies and procedures of this program. If you do not show up to your appointment, we will proceed to enroll the next family on our waiting list.

This document should be included in the family file.

LOS ANGELES UNIFIED SCHOOL DISTRICT
STUDENT EMERGENCY INFORMATION FORM

Parent Information: Please fill out completely and sign where indicated. In a major emergency, it is school district policy to retain students at school for their safety. This form will be used by the school staff when students are released to go home. Please complete electronically or print clearly and return completed form to school.

STUDENT'S LAST NAME | FIRST NAME | M.I.

STUDENT'S LAST NAME	FIRST NAME	M.I.

BIRTH DATE	☐ MALE ☐ FEMALE	GRADE	HOME LANGUAGE

STUDENT'S HOME ADDRESS -- NUMBER	STREET	APT #	CITY	ZIP CODE
MAILING ADDRESS -- NUMBER (IF DIFFERENT FROM ABOVE)	STREET	APT #	CITY	ZIP CODE

PARENT'S / LEGAL GUARDIAN'S LAST NAME	FIRST NAME	RELATIONSHIP TO STUDENT	LIVES WITH? ☐ Yes ☐ No
WORK ADDRESS -- NUMBER	STREET	CITY	ZIP CODE

CONTACT NUMBERS		Indicate which phone to call for each message type:*				EMAIL ADDRESS:
HOME		EMERGENCY	☐ Home	☐ Cell	☐ Work	
CELL		ATTENDANCE	☐ Home	☐ Cell	☐ Work	
WORK		GENERAL INFO	☐ Home	☐ Cell	☐ Work	
TEXT		☐ I authorize receiving text messages and understand that I am responsible for all text related charges.				

PARENT'S / LEGAL GUARDIAN'S LAST NAME	FIRST NAME	RELATIONSHIP TO STUDENT	LIVES WITH? ☐ Yes ☐ No
WORK ADDRESS -- NUMBER	STREET	CITY	ZIP CODE

CONTACT NUMBERS		Indicate which phone to call for each message type:*				EMAIL ADDRESS:
HOME		EMERGENCY	☐ Home	☐ Cell	☐ Work	
CELL		ATTENDANCE	☐ Home	☐ Cell	☐ Work	
WORK		GENERAL INFO	☐ Home	☐ Cell	☐ Work	
TEXT		☐ I authorize receiving text messages and understand that I am responsible for all text related charges.				

FIRST NAME

To the principal: In case you are unable to reach me during any emergency, you are authorized to contact and, if necessary, release my child to any of the following:

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE
NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE
NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE

List any other family members attending this school:

LAST NAME	FIRST NAME	HOME ROOM	GRADE	RELATIONSHIP
LAST NAME	FIRST NAME	HOME ROOM	GRADE	RELATIONSHIP

MILITARY CONNECTED FAMILY: In efforts to provide resources and support to military connected students and their families, please respond to the following:	Immediate family member in the military (Active Duty, Guard, Reserve, or Veteran): ☐YES ☐NO Relationship to Student: _____	Currently Deployed: ☐YES ☐NO Military Branch: _____ Status: ☐Active Duty; ☐Guard; ☐Reserve; ☐Veteran; ☐Deceased

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

The undersigned, as parent/legal guardian of, _____ a minor,
(Print name of the student here)

hereby authorizes the principal or designee, into whose care the student has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to the student upon the advice of any licensed physician and/or dentist. It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the Los Angeles Unified School District ("District") to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary. This authorization is given in accordance with Section 49407 of the California Education Code, and shall remain effective until revoked in writing and delivered to the District. I understand that the District, its officers and its employees assume no liability of any nature in relation to the transportation of the student. I further understand that all costs of paramedic transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my sole responsibility as the student's parent/guardian.

HEALTH ALERTS -- ***List any medical condition which restricts physical activity or requires special attention. Include conditions such as asthma and allergies such as peanut and bee stings. If none, please indicate "none".***

DOES THE STUDENT HAVE HEALTH INSURANCE? (Check One) ☐ YES ☐ NO* **If "Yes":** ☐ Private Health Insurance ☐ Medi-Cal ☐ Healthy Families

MEDI-CAL / HEALTHY FAMILIES ID Number:

1. PRIVATE HEALTH INSURANCE NAME	GROUP NO.	2. PRIVATE HEALTH INSURANCE NAME (If covered under more than one plan)	GROUP NO.
NAME OF DOCTOR / MEDICAL OFFICE		**PHONE NUMBER OF DOCTOR / MEDICAL OFFICE**	

MIDDLE INITIAL

*If the student currently does not have health insurance, information on free or low-cost health care programs is available by calling the District's toll-free HELPLINE 1(866)742-2273.

MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS:	
MY CHILD CURRENTLY TAKES THE FOLLOWING MEDICATIONS:	

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THIS FORM AND DO HEREBY GIVE MY AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT, AND THAT ALL OF THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND CORRECT.

X _____ **DATE**

SIGNATURE OF: (CHECK ONE) ☐ PARENT ☐ LEGAL GUARDIAN CAREGIVER (AFFIDAVIT)

* Selected telephone number must be a direct dial number (no extensions).

HOME LANGUAGE SURVEY/RACIAL-ETHNIC CATEGORY

ENGLISH

Site _____

The California Education Code requires schools to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students.

Your cooperation in helping us meet this important requirement is requested. Please answer the following questions and have your son/daughter return this form to his/her teacher. Thank you for your help.

Name of student _____
Last First Middle Birth date Grade

1. Which language did your son or daughter learn when he or she began to talk? _____
2. What language does your son or daughter most frequently use at home? _____
3. What language do you use most frequently to speak to your son or daughter? _____
4. Name the language in the order most often spoken by the adults at home:
   a. _____
   b. _____
   c. _____

Racial-ethnic heritage of your children: Although you are not required to provide this information, your cooperation will help determine compliance with federal civil rights law. If you decline to provide this information, it will in no way affect consideration of your application or your child's participation in the program. Collection of this information is in accordance with Title VI of the Civil Rights Act of 1964 and is strictly for statistical reporting requirements. If willing, please circle the correct category below:

(1)	(2)	(3)	(4)	(5)	(6)
White-not of Hispanic Origin	Black-not of Hispanic Origin	Hispanic	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander

_____
Signature of Parent/Caretaker

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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

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

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

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

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

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

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

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

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (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.

LOS ANGELES UNIFIED SCHOOL DISTRICT - EXAMINATION BY PRIVATE PHYSICIAN

Name _____ Sex: M___ F___ Birth Date: _____

Address _____ School _____

To the Physician: Please complete both sides and return to the child's school in attached envelope.

BIRTH HISTORY: (Optional)
Pre-natal Complications _____
Birth Weight _____ Delivery _____
Neo-natal Complications _____

DEVELOPMENTAL MILESTONES:
Sat_____ mo. Crawl _____mo. Walked _____mo.
Words_____mo. Sentences_____ mo.
Toilet Trained_____ mo.

MEDICAL HISTORY:
Serious Illnesses or injuries _____
_____
_____
Surgery
Allergic Reactions _____

IMMUNIZATIONS OF (NUMBER DOSES AND DATES):
DPT 1 2 3 4 5
or
TD 1 2 3 4 5
Polio 1 2 3 4 5
Measles _____
Mumps _____
Rubella _____
H.I.B. _____
Hepatitis B _____ (over)
Other _____

(N= Normal. O= Over for Comment.) | Under RX

Date of Examination
Wt._____ Ht. _____
Eyes _____ Vision R:20/ L:20/
Ears _____ Hearing _____
Nose _____
Mouth _____ Speech _____
Throat _____ Tonsils _____
Teeth _____ Orthodontia Needed _____
Heart _____ B.P. _____
Lungs _____
Abdomen _____ Hernia _____
G-U _____
Nervous System _____
Skin _____
Posture _____
(Please indicate deviations from normal)
Other Orthopedic _____
_____
Blood _____ Urine _____
Mantoux Test: Given _____ Read _____
Pos._____ (date) (date)
(Indur. mm) Chest X-ray_____ Results: _____
Neg. _____ (date)

EXAMINATION BY PRIVATE PHYSICIAN (continued)
Currently does this child need help with:
Motor Development_____
Speech_____
Behavior_____
Emotional Growth_____
Has this child had:
Psychological Testing _____
Neurological Referral _____
Psychiatric Referral _____
Other Counseling_____
Current Medication: No_____ Yes _____ What _____
_____

PARENTAL REQUEST: I request that my physician release this completed report to the school.

_____
Parent/Guardian Signature Date

PLEASE Return To:
School_____
Address _____
City_____ Zip_____

Form No. 34-AEH-51
Commodity Code No. 966 12 15306 Repro

Recommendations and Comments:

(Physical Education required by State Law):
Reg._____
Limited or Adaptive _____ Why_____
_____
_____
_____

Signature_____ M.D.
_____ M.D.
(Please type or print name)
Address_____
Phone_____ Date_____

LOS ANGELES UNIFIED SCHOOL DISTRICT - **PERMANENT HEALTH HISTORY**

Students Name _____ Sex: M ____ F ____ Birth Date _____
LAST FIRST MIDDLE MONTH DAY YEAR

Last School or Children's Center Attended: _____
Name
Location _____
City & State
Present grade _____
SPECIAL CLASS OR SCHOOL _____

FAMILY:	Living with Child(Names)		HEALTH
Father			
Mother			
Stepparent			
Others			
	How Many Older	How Many Younger	HEALTH
Brothers			
Sisters			

Has child ever been hospitalized overnight? Yes____ No ____
Name of hospital _____ City _____ State
Dates in hospital _____
Reason for hospitalization _____

Is child on medication? Yes____ No ____
Name of medicine _____
Amount _____ Frequency _____
Are physical activities limited? Yes____ No____
If yes, reason for limitation: _____

Health Care Provider/Physician _____
Date of late physical examination _____
Family Dentist _____
Date of last dental examination _____

CHILD'S ILLNESS (past or present) please check (✓):

	YES	NO		YES	NO
Chickenpox			Frequent sore throat		
Meningitis			Ear aches/infections		
Mumps			Hearing loss		
Rubella(3-day measles)			Speech problem		
Rubeola(10-day measles)			Eye problem		
Whooping Cough			Wears glasses/Contacts		
Positive TB Skin Test			Heart condition/murmur		
Bronchitis			High Blood Pressure		
Pneumonia			Kidney problem		
Asthma			Sugar Diabetes		
Hives or Eczema			Blood disease		
Drug or Other Allergy			Menstrual problem		
Head Injury			Hernia		
Seizures/Unconscious			Parasites(worms)		

Other serious accidents or illness (describe) _____

(Over - to complete, date and sign)

PERMANENT HEALTH HISTORY (continued)

P.o.12s-20802-8

BIRTH HISTORY

MOTHER'S PREGNANCY:	YES	NO
Infections		
Bleeding		
High Blood Pressure		
Toxemia		
Sugar Diabetes		
Other Complications of Pregnancy		
9-Month Pregnancy		
Type of Delivery		

Child's birth weight_____
child's birth condition (check) good _____ poor _____
If poor, describe: _____

ILLNESS DURING FIRST 2 WEEKS OF LIFE:	YES	NO
Trouble breathing		
Seizures		
Cyanosis(blue color)		
Jaundice(yellow color)		
Feeding problems		
Anemia		
Birth defect		
Required incubator		
Went home with mother		

DEVELOPMENT HISTORY

At what age did your child:

Sit alone _____ Crawl _____
Stand alone _____ Walk _____
Say words _____ Use sentences _____
Toilet train _____ Feed self _____

PLEASE CHECK ( ) DOES YOUR CHILD:

	YES	NO		YES	NO
Enjoy learning			Bite nails		
Like school			Suck thumb		
Like other children			Wet bed		
Eat well			Seem shy		
Drink milk			Fall frequently		
Eat Breakfast			Have temper tantrums		
Sleep well			Seem overactive		
Follow directions					

What time does your child go to bed? _____

Do you have any questions or concerns about your child's health? Please list.

Date _____ Parent/Guardian Signature _____

Date _____ History taken by (Name) _____

Title _____

Name of School _____

FORM 34-EH-67 7/88
STK. NO. 815292
C.C.9661215282 REPRO

LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health Services Division

LOS ANGELES UNIFIED SCHOOL DISTRICT

School Name
California, 00000

VERIFICATION OF EMPLOYMENT

PARENT SECTION:

Family ID: _____

Child: _____

California state law (*5 CCR 18084*) requires that families receiving LAUSD early childhood education services document total income. I agree to provide check stubs or other record of wages. **I authorize my employer to release the following information to the early childhood education program named above. I also authorize the early childhood education program to contact my employer to verify any information indicated on this form.**

_____ _____ _____

Parent / Employee Name | Signature of Parent / Employee | Date

EMPLOYER SECTION: *Please complete and return to the location shown above.*

Employer: _____ Phone: _____

Address: _____ Business Hours: _____

Employee Position / Department: _____ Date of Hire: _____

How is the employee paid? ☐Weekly ☐Every 2 Weeks ☐Twice a Month ☐Every 4 Weeks ☐Monthly

Paid by: ☐Cash ☐Check GROSS Earnings Per Pay Period: _____

Possibility of?

Number of Hours Employed Per Week_____ Hourly Rate $ _____ ☐*Tips* ☐*Overtime*

DAYS AND HOURS OF EMPLOYMENT

HOURS	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
FROM:							
TO:							

If working a variable schedule, please check one: ☐Days vary ☐Hours vary ☐Days and hours vary

Please explain: _____

_____ _____ _____

Employer Name/Title | Signature of Employer Representative | Date

LAUSD SECTION:

Means of verification: _____

Notes: _____

Verified By: _____ Date: _____

LOS ANGELES UNIFIED SCHOOL DISTRICT
EARLY CHILDHOOD EDUCATION
SELF-CERTIFICATION OF INCOME

PARENT SECTION:

Name of parent: _____ Family ID: _____

1. Self-certification of **employment income** is requested for the following reason:
   - ☐ The early education program requested that I complete this form because my employer has refused or failed to provide my employment information.
   - ☐ I have asked that my employer not be contacted to verify my employment because that contact could put my employment at risk.
   - ☐ I do not have pay stubs, receipts or other documentation of employment.
   - ☐ Other _____

EMPLOYER	**#1**	**#2**
Date hired:		
Type of work performed:		
Rate of pay: *($___ per ___)*	$	$
How often paid? *(Weekly, monthly, etc.)*		
Paid by: *(Cash, check)*		
Work day hours: *(___ AM - ___ PM)*		
Days worked each week: *(Mon. - Fri.)*		
Total paid for the last month:	$	$

2. Self-certification of **non-employment income** when no documentation is possible:

What type?		
How much?		
How often?		
Why?		

I declare under penalty of perjury that the above information is true and correct to the best of my knowledge. I understand that I may be asked to document my activities each week.

_____ _____

Parent Signature Date

LAUSD SECTION:

Notes: _____

Assessed By: _____ Date: _____

Rev. 3/2013

CALIFORNIA DEPARTMENT OF EDUCATION
Form CD 9600A, (Rev. 01/04)

Child Care Data Collection
Privacy Notice and Consent Form

The United States Department of Health and Human Services (HHS) is gathering information about families who 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 to persons developing child care programs and policies at the state, local, and national levels.

All the information HHS receives about your family and other families will be summed up and reported to Congress every two years. No person or family will be individually identified in reports made to Congress, 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 not wish to give your Social Security Number for this purpose, you may still receive child care assistance. Social Security Numbers will help CDE meet HHS reporting requests and state requirements for program statistics. Authority to ask for your Social Security Number for this purpose is stated 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 the Head of Household Date

_____
Type or Print Name

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

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.

Department of Social Services, Community Care Licensing Division

☐ Los Angeles Northwest Regional Office
6167 Bristol Parkway, Suite 400
Culver City, CA 90230
(310) 337-4333

☐ Los Angeles East Regional Office
1000 Corporate Center Drive, Suite 200B
Monterey Park, CA 91754
(323) 981-3350

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 _____, 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

LOS ANGELES UNIFIED SCHOOL DISTRICT
PARENT/STUDENT ACKNOWLEDGEMENT FORM

EARLY CHILDHOOD EDUCATION PROCEDURES, GUIDELINES AND INFORMATION FOR PARENTS

Dear Parent/Guardian:

Our program annually notifies parents/guardians of their rights to services and programs offered through the Early Childhood Education Division. You must sign a notification form and return it to your children's schools acknowledging that you have been informed of your rights.

Please read the Information for Parents and return the signed form below to the school. Your signature does not constitute consent to take part in any particular program.

---------- Tear-Off ----------

LOS ANGELES UNIFIED SCHOOL DISTRICT

RECEIPT OF ANNUAL NOTIFICATION OF INFORMATION FOR PARENTS

I acknowledge, with my signature below, the receipt of the required annual notification of parent/student rights on behalf of my son/daughter.

Please PRINT the name, birth date and grade of your child.

STUDENT'S NAME:

Last Name Middle Initial	First Name	Birthdate	Grade

Signature of Parent/Guardian

Signature of Student (Grades 6-12)

INFORMATION RELEASE FORM

Under Federal and State law, school districts may share student directory information with authorized individuals, organizations and/or officials. Pursuant to California Education Code section 49073, LAUSD has identified the categories of information listed below as directory information that may be released to the officials and organizations named below. Parents of students 17 years or younger and adult students 18 years or older may request the school principal limit the release of directory information or not release directory information at all. The request to withhold the student directory information is applicable only to the current school year.

INFORMATION RELEASE FORM

PLEASE READ AND COMPLETE THE INFORMATION RELEASE FROM BELOW AND RETURN IT TO YOUR SCHOOL PRINCIPAL. UNLESS THIS FORM IS RETURNED, YOUR STUDENT'S INFORMATION MAY BE RELEASED AS INDICATED.

LOS ANGELES UNFIED SCHOOL DISTRICT PARENT STUDENT HANDBOOK

SCHOOL NAME: _____ DATE: _____

STUDENT NAME: (Please Print)	Date of Birth:	Grade:
Address:	City:	Zip Code:
Telephone Number:	Record Room:	

STUDENT DIRECTORY INFORMATION

☐ 1. I do not wish to have any directory information released to any individual or organization.

OR

☐ 2. I request to withhold the directory information according to the box(es) I check below:

	DO NOT RELEASE
PTA	
HEALTH DEPT.	
ELECTED OFFICIALS	
DCFS	
DEPT. OF MENTAL HEALTH	
PROBATION DEPT.	

	DO NOT RELEASE
• Name	
2. Address	
3. Telephone Number	
4. Date of Birth	
5. Dates of Attendance	
6. Previous School(s)	

NEWS MEDIA RELEASE OF INFORMATION

☐ My child may be interviewed, photographed, or filmed by members of the news media.

☐ My child may not be interviewed, photographed, or filmed by members of the news media.

_____ _____

Signature of Parent/Guardian (if student is under 18) Signature of Student (if student is 18 or older)

Los Angeles Unified School District

ANNUAL PESTICIDE USE NOTIFICATION

The District has adopted an Integrated Pest Management (IPM) policy. This policy includes notifying parents/guardians of pesticide use. During the school year, it may be necessary to apply pesticides at your child's school to avoid serious health problems posed by pests and/or maintain the integrity of a structure. However, should you feel that your child's or your (for school staff) health and/or behavior could be influenced by exposure to pesticide products, you are notified as follows:

- An application of products on the Approved List may be applied during the school year (see attached list of pesticide products that have been approved for use at District sites).
- In the event the use of a product is required that is not on the Approved List, you will be notified 72 hours in advance. (Exception: Emergency circumstances that warrant an immediate response).
- Additional information regarding pesticide products, including those on the District's Approved List, is available online at http://www.cdpr.ca.gov

Please complete, detach and return the form below to the school's main office, indicating whether you wish to be pre-notified each time a pesticide is scheduled to be used at the school.

----------*Cut here and return if applicable*----------

PARENT/GUARDIAN REQUEST FOR NOTIFICATION

I would like to be pre-notified every time a pesticide application is to take place at my child's school (i.e., in addition to annual notification). I understand that the notification will be sent home with my child, or provided to me as a school staff member at least 72 hours before application. (Exception: Emergency circumstances that warrant an immediate response).

I do not need to be notified every time a pesticide is to take place at the school. I understand that I will receive an annual notification in the Parent Student Handbook, or by other means, of pesticides approved for use at schools.

Child's name (print): _____

Room Number: _____

School: _____

Name of parent/guardian (print): _____

Signature of parent/guardian: _____ Date: _____

Note to Site Administrator

File the original in the Main Office. If the above "I would like to be pre-notified" box is checked, forward a copy of this notice via school mail to Pest Management Department as soon as they are received from the parents and staff.

Maintenance and Operations Central 3 and Special Services
1240 S. Naomi Ave., Los Angeles, CA 90021
Attn.: Adrian Saldivar

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.

   Department of Social Services, Community Care Licensing Division

   ☐ Monterey Park Regional Office
   1000 Corporate Center Drive, Suite 200B, MS 29-15
   Monterey Park, CA 91754
   (323) 981-3350 FAX (323) 981-3355

   ☐ Culver City Regional Office
   300 N. Continental Blvd., Suite 290B
   El Segundo, CA 90245
   (424) 301-3077 FAX (424) 301-3200

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 _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

TOLUCA LAKE CSPP
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

LOS ANGELES UNIFIED SCHOOL DISTRICT
REFERENCE GUIDE

REF-041180.1
October 2, 2018

ATTACHMENT A

Los Angeles Unified School District

Migrant Education Program
Family Work Questionnaire

Your children may be eligible to receive *FREE* educational and health services.
Possible services may include:

- After-School Tutoring
- Saturday School
- Preschool Programs
- Help Recovering High School Credits
- Summer College Academies
- Summer Outdoor Camp
- Summer Science Academies
- Dental Screenings/Medical Referrals

Parents receive training on:
How to become involved in their children's schools, how to support their children's academic success, requirements for college admissions and other services. We also provide information for classes to obtain a GED certificate, which is an equivalent to a high school diploma.

Have you or any family member moved to work or seek work in agriculture within the last 3 years? Yes ❑NO❑
If you answered YES, please answer the next question
Did your children move with you during the time you worked or went to seek work? Yes ❑NO❑

(Please check all the agricultural and fishing jobs, temporary and seasonal, that applies.)

❑ **Field Work/ Agriculture** Examples: (plant, prune, pick, harvest, pack, sort or transport fruits, vegetables, grains, or other crops; soil preparation, irrigation, fumigation, etc.)	❑ **Orchard** Examples: (pick, prune, sort fruit, nut trees, vines, etc.)	❑ **Nursery** Examples: (plant, cultivate, harvest flowers, plants, trees, bushes, herbs, sod, etc.)	❑ **Fishing** Examples: (catch, sort, pack, process, transport fish or shellfish, etc.)
❑ **Dairy/Farm/Ranch/ Livestock** Examples: (milking, cattle feeding, transporting animals; raising farm animals such as poultry, goats, pigs, etc.; and sale of its products such as milk, eggs, cheese, etc. for someone or for family support.	❑ **Packing** Examples: (process, store, freeze, can, pack fruits, vegetables, meats, etc.)	❑ **Food Processing** Examples: (prepare, process foods like tomato sauce, fruit jellies, chili sauce; processing of wheat or flour for tortilla items, pack cut or pack an assortment of meats.)	❑ **Forestry/Lumber** Examples: (plant, grow, cultivate, harvest trees; thinning and vegetation control, etc.)

Important: Proof of family income or immigration status is *NOT* required to receive services.

Please provide the following information to your school:

Parent(s)/Guardian(s) Name: _____ Date: _____

Address: _____

Telephone: _____

What is the best time to call you? ❑ 8am-12pm ❑ 12pm-6pm ❑ 6pm-8pm

Student's Name: _____

School Name: TOLUCA LAKE CSPP Grade: _____

For more information, call the Los Angeles Unified School District, Migrant Education Office at: (213) 241-0510

*** TO HOME SCHOOL STAFF ***

Please return this survey to the Migrant Education Office, Beaudry Building, 29TH Floor, within two weeks of student's enrollment, in order to make services available to eligible families. Please call (213) 241-0510 for more information.

CALIFORNIA IMMUNIZATION REQUIREMENTS FOR

PRE-KINDERGARTEN

(any private or public child care center, day nursery, nursery school, family day care home, or development center)

Doses required by age when admitted and at each age checkpoint after entry[1]:

AGE WHEN ADMITTED	TOTAL NUMBER OF DOSES REQUIRED OF EACH IMMUNIZATION[2,3]				
2 through 3 months	1 Polio	1 DTaP	1 Hep B	1 Hib	
4 through 5 months	2 Polio	2 DTaP	2 Hep B	2 Hib	
6 through 14 months	2 Polio	3 DTaP	2 Hep B	2 Hib	
15 through 17 months	3 Polio	3 DTaP	2 Hep B		1 Varicella
		On or after the 1st birthday:		1 Hib[4]	1 MMR
18 months through 5 years	3 Polio	4 DTaP	3 Hep B		1 Varicella
		On or after the 1st birthday:		1 Hib[4]	1 MMR

1. A pupil's parent or guardian must provide documentation of a pupil's proof of immunization to the governing authority no more than 30 days after a pupil becomes subject to any additional requirement(s) based on age, as indicated in the table above (Table A).
2. Combination vaccines (e.g., MMRV) meet the requirements for individual component vaccines. Doses of DTP count towards the DTaP requirement.
3. Any vaccine administered four or fewer days prior to the minimum required age is valid.
4. One Hib dose must be given on or after the first birthday regardless of previous doses. Required only for children who have not reached the age of five years.

DTaP = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine
Hib = Haemophilus influenzae, type B vaccine
Hep B = hepatitis B vaccine
MMR = measles, mumps, and rubella vaccine
Varicella = chickenpox vaccine

INSTRUCTIONS:

California pre-kindergarten (child care or preschool) facilities are required to check immunizations for all new admissions and at each age checkpoint.

UNCONDITIONALLY ADMIT a pupil age 18 months or older whose parent or guardian has provided documentation of any of the following for each immunization required for the pupil's age as defined in table above:

- Receipt of immunization.
- A permanent medical exemption in accordance with 17 CCR section 6051.
- A personal beliefs exemption (filed prior to 2016) in accordance with Health and Safety Code section 120335.

CONDITIONAL ADMISSION SCHEDULE FOR PRE-KINDERGARTEN

Before admission a child must obtain the first dose of each required vaccine and any subsequent doses that are due because the period of time allowed before exclusion has elapsed.

DOSE	EARLIEST DOSE MAY BE GIVEN	EXCLUDE IF NOT GIVEN BY
Polio #2	4 weeks after 1st dose	8 weeks after 1st dose
Polio #3	4 weeks after 2nd dose	12 months after 2nd dose
DTaP #2, #3	4 weeks after previous dose	8 weeks after previous dose
DTaP #4	6 months after 3rd dose	12 months after 3rd dose
Hib #2	4 weeks after 1st dose	8 weeks after 1st dose
Hep B #2	4 weeks after 1st dose	8 weeks after 1st dose
Hep B #3	8 weeks after 2nd dose and at least 4 months after 1st dose	12 months after 2nd dose

CONDITIONALLY ADMIT any pupil who lacks documentation for unconditional admission if the pupil:

- has commenced receiving doses of all the vaccines required for the pupil's age (table on page 1) and is not currently due for any doses at the time of admission (as determined by intervals listed in Conditional Admission Schedule, column entitled "EXCLUDE IF NOT GIVEN BY"), or
- is younger than 18 months and has received all the immunizations required for the pupil's age (table on page 1) but will require additional vaccine doses at an older age (i.e., at next age checkpoint), or
- has a temporary medical exemption from some or all required immunizations (17 CCR section 6050).

Continued attendance after conditional admission is contingent upon documentation of receipt of the remaining required immunizations. The pre-kindergarten facility shall notify the pupil's parent or guardian of the date by which the pupil must complete all remaining doses.

Questions?

See the California Immunization Handbook at ShotsForSchool.org

ELIGIBILITY / WAITING LIST FOR LAUSD EARLY CHILDHOOD EDUCATION SERVICES

PRIORITY RANK

Early Education Center / School: _____ **Estimated Daily Fee:** _____

TO BE COMPLETED BY PARENT / CARETAKER	**GROSS MONTHLY INCOME** (BEFORE taxes) Include child support, cash aid and any other income received
NAMES:	
A. **Relationship:**	**$**
B. **Relationship:**	**$**
☐ *I am a single parent and can provide proof*	**TOTAL FAMILY INCOME: $**
Address:	
Best phone to reach me - Home/Cell: Work:	

CHILDREN NEEDING SERVICES	**DATE OF BIRTH**	**HOURS OF CARE NEEDED**
Child Name:		
Child Name:		
Number of other children in the family under age 18: _____	**TOTAL FAMILY SIZE:**	

I am requesting early childhood education services for the child(ren) listed above. In order to remain on the waiting list I understand that it is my responsibility to update this information at least once every six months or as changes occur. I understand that enrollment at this location is based on space availability, enrollment priority and priority rank. When notified that space is available, I understand that LAUSD staff will verify all information on this form to make sure my child is eligible before he/she can be enrolled.

Parent Name	**Signature of Parent**	**Date**

FOR LAUSD USE ONLY

Date Received by LAUSD:	Date Child Enrolled:
Date(s) Updated:	Date Removed from List:

CCTR	**CSPP FULL DAY**	**CSPP PART DAY**
Enrollment Priority: 1st priority: ☐ Child Protective Services or At Risk 2nd priority: ☐ Cash aid recipient ☐ Income eligible ☐ Homeless **Meets need requirement:** ☐ Working ☐ Seeking employment ☐ Attending vocational training ☐ Incapacitated ☐ Homeless and seeking permanent housing	**Enrollment Priority:** 1st priority: ☐ Child Protective Services or At Risk 2nd priority: ☐ Four year old child in an income eligible family 3rd priority: ☐ Three year old child in an income eligible family **Meets need requirement:** ☐ Working ☐ Seeking employment ☐ Attending vocational training ☐ Incapacitated ☐ Homeless and seeking permanent housing	**Enrollment Priority:** 1st priority: ☐ Child Protective Services or At Risk 2nd priority: ☐ Four year old child in an income eligible family 3rd priority: ☐ Four year old child in a family whose income is no more than 15% over the income limit 4th priority: ☐ Three year old child in an income eligible family

COMMENTS:

CALIFORNIA IMMUNIZATION REQUIREMENTS FOR

Child Care

CDPH

REFERENCE Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380; California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, Sections 6000-6075

INSTRUCTIONS To attend child care, children must have immunizations outlined below by age. Parents must present their child's Immunization Record as proof of immunization. Copy the full date of each shot onto the blue California School Immunization Record card and then determine if the child is up-to-date. Blue cards are available free from the Immunization Coordinator at your local health department. As the child care provider, it is your responsibility to follow up regularly until all shots are finished.

IMMUNIZATIONS (SHOTS) REQUIRED TO ATTEND CHILD CARE, BY AGE

Age When Entering	Immunizations (Shots) Required
2–3 months	1 each of Polio, DTaP, Hib, Hep B
4–5 months	2 each of Polio, DTaP, Hib, Hep B
6–14 months	3 DTaP 2 each of Polio, Hib, Hep B
15–17 months	3 each of Polio, DTaP 2 Hep B 1 MMR, on or after the first birthday[1] 1 Hib, on or after the first birthday[1, 3]
18 months–5 years	3 Polio 4 DTaP 3 Hep B 1 MMR, on or after the first birthday[1] 1 Hib, on or after the first birthday[1, 3] 1 Varicella (chickenpox)[2]

Vaccines

DTaP: Diphtheria, tetanus, and pertussis combined vaccine.

Hib: *Haemophilus influenzae* type b vaccine; required only for children up to age 4 years, 6 months.

MMR: Measles, mumps, and rubella combined vaccine.

Hep B: Hepatitis B vaccine.

Varicella: Chickenpox vaccine.

You may admit a child who is lacking one or more required vaccine doses if the dose(s) is not currently due **on the condition** that they receive the remaining dose(s) when due, according to the schedule above. You will need to review records to make sure this occurs. If the maximum time interval between doses has passed, the child cannot be admitted until the next immunization is obtained.

[1] Receipt of the dose up to (and including) 4 days before the birthday will satisfy the child care entry immunization requirement.

[2] If a child had chickenpox disease and this is indicated on the Immunization Record by the child's physician, they meet the requirement. Write "disease" in the chickenpox date box on the blue card.

[3] Required only for children who have not reached the age of 4 years 6 months.

WHEN NEXT SHOTS ARE DUE

Polio #2	6–10 weeks after 1st dose
Polio #3	6 weeks–12 months after 2nd dose
DTaP #2, #3	4–8 weeks after previous dose
Hib #2	2–3 months after 1st dose
DTaP #4	6–12 months after 3rd dose
Hep B #2	1–2 months after 1st dose
Hep B #3	Under age 18 months: 2–12 months after 2nd dose and at least 4 months after 1st dose Age 18 months and older: 2–6 months after 2nd dose and at least 4 months after 1st dose

EXEMPTIONS The law allows parents/guardians to submit an exemption from immunization requirements based on their personal beliefs or medical conditions. For children with medical exemptions, the physician's written statement should be submitted. Child care staff should maintain an up-to-date list of pupils with exemptions, so they can be excluded quickly if an outbreak occurs.

For more information, visit ***ShotsForSchool.org***

Registration Form

Introduction

The County of Los Angeles Child Care Planning Committee (CCPC) has created the Los Angeles Centralized Eligibility List (LACEL) to help connect low- income families with child care and development subsidies as child care spaces and funding become available. By completing this form, you are registering on the LACEL. The information you provide on this form will help determine your eligibility for a child care subsidy. Registration on the LACEL allows a child care and development program to contact you if and when a subsidized child care space becomes available. At that time, the program staff will verify the information you provided on this form to make sure you are eligible before you are invited to enroll your child. All information is handled confidentially.

For more information on the LACEL, please contact the County of Los Angeles Office of child Care at (213)974-1664 or visit the web site at www.childcare.lacounty.gov.

COMPLETE BOTH SIDES OF FORM	**Application Date:**	
Parent/Guardian #1 Information		
Last name:	First name:	
Street address:	City:	Zip Code:
Home phone:	Work/other phone:	Primary language:
Name of employer/school:	Work/other phone:	
Indicate if your household is a	□ Single parent family	□ Two parent family
Parent/guardian #2 Information (Complete If there is another parent/guardian residing in the same home)		
Last name:	First name:	
Name of employer/school:	Work /school zip code:	Work /other phone:
Reason for Needing Child care(Check all that apply)	**Parent/Guardian # 1**	**Parent /Guardian # 2**
Working	□	□
Attending School or Job Training	□	□
Medically Incapacitated/Disabled	□	□
Looking for Work	□	□
Homeless/Seeking housing	□	□
Migrant Worker	□	□
Part-day educational preschool experience for child	□	□
Cal Works Participation (Cash aid)		
Are you currently receiving cash aid? □ Yes □ No	If NO, have you received cash aid within The last two years? □ Yes □ No	If YES, last date of cash aid payment -------/--------/--------/

Monthly Income and Sources (Enter total dollars, before taxes and deductions for each source of income for parents/guardian the household)		
	Parent/Guardian #1	Parent/Guardian #2
Work/Employment	$	$
Child Support	$	$
Spousal Support	$	$
State Disability	$	$
Unemployment benefits	$	$
Sales/Work Commissions	$	$
Cash Aid (Cal Works)	$	$
Worker's Compensation	$	$
Social Security	$	$
SSI/SSP	$	$
Other(explain):	$	$

Children Living at Home (All children under 18 who are members of the family Attach an additional page if needed.

Check only if child care is needed.

First and Last Name	Gender	Date of Birth	Full-time	Part –time	Evenings/Weekends
1.	F M		☐	☐	☐
2.	F M		☐	☐	☐
3.	F M		☐	☐	☐

Foster Care Payments.

Are you currently receiving foster care payments for any of the children listed above? Check which child and write the monthly amount.

☐ **Child # 1 $**_____ ☐ **Child # 2 $**_____ ☐ **Child # 3 $**_____

Special Needs (Check all that apply).

	Child # 1	Child # 2	Child # 3
Child Protective Services			
Child has IFSP (Individual Family Services Plant) or IEP (Individual Education Plan)			
Child receives services through regional Center or the local School District.			
Social emotional/behavior			
Ongoing health problems			
Developmental delays			
Speech/communication			
Vision or haring			
Other (please explain):			

Preferred Location or Program (List below your preferred zip code location if different from home or work. You may list the name of the program you prefer for your child.

Child # 1	Zip Code:	Name of Program/Agency:
Child # 2	Zip Code:	Name of Program/Agency:
Child #3	Zip Code:	Name of Program/Agency:

School Age Children (Complete for school age children only)

Child # 1	Grade	Name of Program/Agency:
Child # 2	Grade	Name of Program/Agency:
Child # 3	Grade	Name of Program/Agency: