RIALTO UNIFIED SCHOOL DISTRICT
EARLY EDUCATION
State Preschool Enrollment
815 South Willow Avenue, Rialto CA 92376
(909) 421-4201 Fax: (909) 421-7602

Please ensure you complete the checklist below before calling for an appointment. Any missing items will result in a delay of your enrollment process. Qualification is based on income with priority given to the 4 year olds. Enrollment for 4 year olds will begin in March and enrollment for 3 year olds will begin in May.

*****ENROLLMENT BY APPOINTMENT ONLY*****

❒ **INCOME:** Must be for the ***last 30 days*** or the ***previous month***
- ❒ If paid WEEKLY: 4 consecutive paystubs
- ❒ If paid BI-WEEKLY: 2 consecutive paystubs
- ❒ If paid MONTHLY: 1 current paystub

The following are examples of different sources of income.
Please provide all income that applies below:
- Pay Stubs (must be consecutive)
- Self-Employed (Taxes, bank history, invoice/receipts) *****see clerk for additional form***
- Unemployment/ State Disability/ Worker's Compensation (paystubs or award letter)
- Military Pay and Allowances
- SSI/Social Security (Yearly Letter with **current** check, bank statement of direct deposit or print out from Social Security Office).
- Survivor's and Retirement Benefits (Letter with **current** check or bank statement if it's direct deposit)
- CalWorks/Cash Aid/Food Stamps- **Verification of Public Assistance Form** can be picked up at the County office.
- Child Support/Alimony ***see clerk for additional form*
- Adoption Assistance
- Foster Care Assistance (child enrolling and their siblings)

❒ Employment Verification Form for each working parent in the home (forms enclosed)

❒ Birth records, Foster Care Placement documents, or Legal Guardianship documents for **ALL children** in your care under the age of 18.

❒ Immunization Record (immunization requirements enclosed)

❒ T.B. Skin Test (PPD-Mantoux)

❒ Recent Report of Health Examination (form is provided in the packet)
Must be signed by physician and stamped by clinic

❒ Proof of Address for the parent/guardian

❒ Photo I.D. for the parent/guardian

RIALTO UNIFIED SCHOOL DISTRICT
HEALTH SERVICES
815 S. Willow Avenue, Rialto, CA 92376 • Tel (909) 820-8150 • Fax (909) 873-4303

PARENTS' GUIDE TO IMMUNIZATIONS REQUIRED FOR PRESCHOOL

18 months - 5 years	3 Polio 4 DTaP 3 Hep B 1 MMR on or after the 1st birthday 1 Hib on or after the 1st birthday** 1 Varicella

**Required only for children less than 4 years, 6 months

Polio = Poliomyelitis
DTaP = Diphtheria, Tetanus, and Pertussis
Hib = Haemophilus Influenzae type B
Hep B = Hepatitis B
MMR = Measles, Mumps, Rubella
Varicella = Chickenpox

Parents must show their child's Immunization Record as proof of immunization.

WHY YOUR CHILD NEEDS SHOTS:
The California School Immunization Law requires that children be up-to-date on their immunizations (shots) to attend a preschool.

Diseases like measles spread quickly, so children need to be protected before they enter. Staff will check your child's Immunization Records before they start.

THE LAW:
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.

WHAT YOU WILL NEED FOR ADMISSION:
To attend a preschool, your child's Immunization Record must show the date for each required shot above. If you do not have an Immunization Record, or your child has not received all required shots, call your doctor now for an appointment.

If a licensed physician determines a vaccine should not be given to your child because of medical reasons, submit a written statement from the physician for a **medical exemption** for the missing shot(s), including the duration of the medical exemption.

A personal beliefs exemption is no longer an option for entry into preschool; however a valid personal beliefs exemption filed with a school facility before January 1, 2016 is valid until entry into the next grade span (transitional kindergarten through 6th grade) and may be transferred between preschool facilities in California. You must also submit an immunization record for all required shots not exempted.

Have questions? Visit ShotsForSchool.org or contact your local health department 800-722-4794.

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(909) 421-4201 Fax: (909) 421-7602

Authorization to Release Information

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

Rialto Unified School District – Early Education, to verify all information utilized to determine my family's eligibility during the time I am enrolled in their program.

I authorize the sharing of information between agencies to verify my income, and eligibility. Agencies that may be contacted include, but are not limited to, the Department of Public Social Services, Department of Child Support, training sites, schools, social service agencies, referring physicians, emergency shelters, and employers.

I declare under penalty of perjury that all information that I provided to Rialto USD – Early Education is true and correct, and that all documents submitted to Rialto USD – Early Education, are to the best of my knowledge true and correct. Failure to comply with these rules will result in termination from the Rialto USD – State Preschool Program.

_____ _____ _____
Employee/Parent Signature | Employee ID # or Social Security # | Date

EMPLOYMENT/ INCOME VERIFICATION

This is a State funded preschool program and therefore we must have confirmation of all income and work hours of parents whose children are enrolled in our program. Please release the following information for our records. All information is confidential, and used only for family eligibility purposes.

_____
Name of Employee Phone

_____
Address City State Zip code

_____
Name of Employer Contact Person

_____
Address City State Zip code

Employer Phone _____ Employer Email _____

Hire Date _____ Work Hours: Start_____End_____Job Title_____

Days of Employment: Sun_____Mon_____Tue_____Wed_____Thurs_____Fri_____Sat_____

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 EMPLOYEE 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: _____

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Authorization to Release Information

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_____ _____ _____
Employee/Parent Signature Employee ID # or Social Security # Date

EMPLOYMENT/ INCOME VERIFICATION

This is a State funded preschool program and therefore we must have confirmation of all income and work hours of parents whose children are enrolled in our program. Please release the following information for our records. All information is confidential, and used only for family eligibility purposes.

Name of Employee _____ Phone _____

Address _____ City _____ State _____ Zip code _____

Name of Employer _____ Contact Person _____

Address _____ City _____ State _____ Zip code _____

Employer Phone _____ Employer Email _____

Hire Date _____ Work Hours: Start_____End_____Job Title_____

Days of Employment: Sun_____Mon_____Tue_____Wed_____Thurs_____Fri_____Sat_____

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 EMPLOYEE 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
815 South Willow Avenue, Rialto CA 92376
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Applicants for Early Education Preschool Programs

NOTIFICATION OF DISTRICT MISREPRESENTATION POLICY

The California Department of Education, Early Education Division, requires the Office of Early Education to inform all families receiving services funded by Early Education, of the Rialto Unified School District Misrepresentation Policy.

The information I have provided to the Rialto Unified School District verifying my income in order to qualify for specific early education preschool services is correct. I understand that all cases of misrepresentation will be referred to the Office of the San Bernardino County District Attorney.

_____
Applicant's Name (Print)

_____ _____
Applicant's Signature Date

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:

Vision:

Developmental:

Language/Speech:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

Allergies: medicine:

Insect stings:

Food:

Asthma:

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

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

STUDENT HEALTH HISTORY

Student Name: _____ **Date of Birth:** _____

School: _____ **Grade:** _____

Please read this form and check any illnesses or conditions your child has.
Write/list health conditions, medications, explanations to any checked conditions under the "comments" section.

- ☐ **No Known Health Problems**
- ☐ Serious accidents or hospitalizations
- ☐ Allergies requiring treatment: _____
- ☐ Treatment required: _____
- ☐ Diabetes: Insulin dependent: ☐ Yes ☐ No
- ☐ Epilepsy/Seizures
- ☐ Date of Late Seizure: _____ Type of Seizure: _____
- ☐ Hearing Loss: ☐ Right ☐ Left Hearing Aids: ☐ Yes ☐ No
- ☐ Psychological Problems Diagnosis: _____
- ☐ Asthma
- ☐ ADHD / ADD
- ☐ Autism
- ☐ Birth Defects / Genetic Disorders
- ☐ Blood / Bleeding Disorders
- ☐ Cerebral Palsy
- ☐ Cancer / Leukemia
- ☐ Heart Problems / Heart Surgery
- ☐ Kidney Disorder/Bladder Problems
- ☐ Vision Impairment
- ☐ Positive PPD/TB skin test: Chest x-ray date and results: _____
  Treatment required: ☐ Yes ☐ No If YES, explain: _____
- ☐ Requires "specialized health procedure". **Explain under "Comments".**

Comments / Other Conditions / Medications: _____

_____

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN:
(What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH _____
DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

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

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

PARENT'S SIGNATURE	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: 3737 Main Street, Suite 700, Riverside, CA 92501

   Licensing Office Telephone #: (951) 782-4200

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.

Preschool
_____
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

NOTE: ***This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.***

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

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

Community Care Licensing

ADDRESS

3737 Main Street, Suite 700

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Riverside	92501	(951) 782-4200

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)
Preschool	

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

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

RIALTO UNIFIED SCHOOL DISTRICT
EARLY EDUCATION
815 South Willow Avenue, Rialto CA 92376
(909) 421-4201 Fax: (909) 421-7602

Child's Name_____D.O.B_____Site_____
(Please initial next to each statement)

_____ **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.

_____ **ATTENDANCE PROCEDURES**
I understand the person(s) authorized to pick up or drop off my child must be 18 years of age or older. Authorized persons **must** also be listed on child's emergency card and are able to present a photo ID upon request. My child will not be released to anyone not listed on the emergency card. **NO VERBAL AUTHORIZATIONS WILL BE ACCEPTED.**

_____ **I understand my child is expected to attend preschool each day, Monday through Friday for the entire 3 hours. I further understand my child must be dropped off and picked up on time every day.**

_____ I understand that I may ask the preschool office for help in locating social services to help my child or my family.

_____ **CONDITIONS FOR TERMINATION**
Students may be terminated from the preschool program for 10 or more absences, 3 or more unexcused absences or because Students and /or their parent become abusive, jeopardizing the physical, mental, or emotional health of children or employees. The state preschool program shall be a safe environment, for all students and staff. Also, my child may be terminated due to 3 or more late drop-offs and/or early or late pick-ups.

_____ **ANIMAL CONSENT**
Throughout the school year we may have animals in the preschool classroom. We will have them either for observation purposes for an instructional unit or as a class pet for students to develop the responsibility of caring for pets. Students are always interested in petting and handling the animals that visit as well as caring for pets. Students are taught how to safely and carefully handle the animals. Please indicate if you DO or if you DO NOT want your child to participate by handling and caring for the animal.

_____ **Yes**, my child may handle the animals that will be in the class.

_____ **No**, I do not want my child to handle any of the animals that will be in the class.

_____ **MEDIA RELEASE**
Permission for my child to be photographed, videotaped, or interviewed by the news for any media reason is granted to the Rialto Unified School District. I also give permission for the Rialto Unified School District to use my child's photograph or words in district publications or on its website. I understand that this permission also applies to classroom displays.

_____**Yes**, my child may appear in pictures taken for the media such as newspapers or television.

_____**No, I do not** want my child to appear in pictures taken for the media such as newspapers or television.

_____ **STUDENT RECORDS**
When your child moves on to kindergarten or transfers to a different preschool in Rialto Unified School District, your child's teacher will forward your child's records to the new teacher. These will include information about your child's development progress, student work samples, and emergency contact information. *It will **not** include: the personal financial records you submitted to qualify for the State Preschool Program.*

_____ **PARENTAL RIGHTS**
I hereby acknowledge that I have been notified of the rights of parents or guardians as specified in the Education Code (E.C) of the State of California.

_____ _____
Signature of Parent or Guardian **Date**

Please Print

Rialto Unified School District – Registration Form

Use Black Ink

Student Information

Legal Last Name	Legal First Name	Legal Middle Name

Grade	Retained? If Yes, What Grade?	Also Known As (other names used):	Social Security Number

Address	Apt./Space	☐ Rialto ☐ San Bernardino ☐ Colton ☐ Fontana Other:	City	Zip Code

Mailing address, if different	City	Zip Code

Phone Number	Date of Birth	Place of Birth (City, State)	Sex
			☐ Male ☐ Female

Family Information (if there is a custody/restraining order for child, please provide a copy)

Name of Person Enrolling Student:		☐ Mother ☐ Father ☐ Foster Parent ☐ Legal Guardian ☐ Caregiver
Parent 1: Name of Legal Father:		☐ Lives with ☐ Not in Home
Parent 2: Name of Legal Mother:		☐ Lives with ☐ Not in Home

Children Living In the Home

Name	School	DOB	Name	School	DOB

Previous School Information – Last School of Attendance Listed First

1. Name of School/District	City and State	Grade	Date Last Attended
2. Name of School/District	City and State	Grade	Date Last Attended
Has student attended a Rialto School? (ex: Preschool) ☐ Yes ☐ No	If yes, name of school:	Grade	Date Last Attended

What is the date that the student first entered school in the U.S.A.? Month: Year:

Attendance problems: ☐ Yes ☐ No **Discipline problems/Expulsions:** ☐ Yes ☐ No

Home Language Survey

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:

1. What language did your son or daughter learn when he or she first 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. What language is most often spoken by the adults at home? _____

If answers to questions one through three indicate a language other than English, state law requires testing for English Proficiency. You will be notified of the results.

Standardized Testing and Reporting Data

The California State Department of Education requests information regarding the highest level of education completed by the enrolling parent/guardian. Please check.

Parent 1

☐ Not a high school graduate ☐ High school graduate
☐ Some college ☐ College graduate
☐ College degree from a 4-year university, with additional coursework in graduate school

Parent 2

☐ Not a high school graduate ☐ High school graduate
☐ Some college ☐ College graduate
☐ College degree from a 4-year university, with additional coursework in graduate school

Prior Special Education Programs

Please provide the following information to assist in your child's placement in school:

☐ My child has **not** participated in any special program.
☐ My child has had special testing.
☐ My child has participated or is participating in the program(s) checked below:

☐ Adaptive Physical Education ☐ Hearing Impaired
☐ Learning Disabled (LD) ☐ Visually Impaired
☐ Emotionally Disabled (ED) ☐ Speech Therapy
☐ Special Day Class (SDC) ☐ Severely Handicapped
☐ Resource Specialist Program (RSP)

My signature certifies that all information provided is accurate. I understand that changes in address, telephone numbers, and/or emergency information must be reported to the school within 24 hours for the safety of my student.

SS-26E (11/18)

Parent/Guardian Signature:_____ Date:_____

Office Use Only

School Year:_____
Grade:_____
Date:_____
Student Number:_____
School Assigned:_____
Class Assigned:_____
Start Date:_____
Teacher:_____
Birth Verification:_____
Enter Code:____ ☐ Home School
☐ Overflow ☐ Inter/Intra
☐ Other_____
Address Verification:
☐ Utility/Rent Receipt
☐ Affidavit of Residence
☐ Other:_____
Staff Signature:_____

Parents/Guardians please fill out the following:

Ethnicity

Please select one:

Is the child Hispanic or Latino?

☐ Yes, Hispanic or Latino
☐ No, Not Hispanic or Latino

Race

Please select child's Race:

☐ American Indian or Alaska Native (Origins in North, Central or South America)
☐ African American or Black
☐ Cambodian
☐ Chinese
☐ Filipino/Filipino American
☐ Guamanian
☐ Hawaiian
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Tahitian
☐ Vietnamese
☐ White (Origins in Europe, North Africa or the Middle East)

RIALTO UNIFIED SCHOOL DISTRICT
EARLY EDUCATION
815 South Willow Avenue, Rialto CA 92376
(909) 421-4201 Fax: (909) 421-7602

CUSTODY MATTERS

Parent Disputes over Custody in School Setting

Custody disputes must be handled by the courts. The school has no legal jurisdiction to refuse a biological parent access to their child. The only exception is when a signed restraining order or proper divorce papers, specifically stating visitation limitations, are on file in the school office. Any student release situation which leaves the student's welfare in question will be handled at the discretion of the site administrator or designee. Should any situation become a disruption to the school, law enforcement will be contacted and an officer will be requested to intervene. Unless Education Rights have been revoked, both parents have access to student records.

Parents are asked to make every attempt not to involve school sites and their personnel in custody matters.

The school will make every attempt to reach the custodial parent when a parent or any other person not listed on the emergency card attempts to pick up a child.

We, _____ & _____
(Parent-A) (Parent-B)

the parents of, _____ have read and understood the
(Student's Name)

above statement.

_____ _____
Parent-A Signature Date

_____ _____
Parent-B Signature Date

Office Use Only

Date Received_____ Received by:_____

Enrollment Date:_____ Site Enrolled:_____

EMERGENCY INFORMATION CARD

School :

STUDENT: LAST | FIRST | STUDENT # | SEX

BIRTHDATE | GRADE

ADDRESS | CITY | ZIP CODE

PARENT/LEGAL GUARDIAN NAME | HOME PHONE NUMBER

Father's Name	Place of work	Work #	Home #	Cell #
Mother's Name	Place of work	Work #	Home #	Cell #

Significant Health Needs (Allergies, Medical Problems)

Medications:

Father's E-mail

Mother's E-mail

Siblings: School:

General Release for Newspapers, T.V., Radio and Internet: Please check one only:

Yes☐ No☐ My child has permission to be photographed or audio/videotaped for school purposes.

Yes☐ No ☐ My child has permission to have His or her picture/work used in or posted on District Internet Website or Publications.

HEALTH INSURANCE PLAN: ☐ MOLINA ☐ KAISER ☐ IEHP ☐ Medi-Cal ☐ OTHER (Specify)_____

PLAN ID #_____ PHYSICIAN:_____ PHONE:_____

PREFERRED HOSPITAL_____ PHONE:_____

I GIVE THE SCHOOL PERMISSION TO BILL MY INSURANCE FOR MEDICAL SERVICES RENDERED AT SCHOOL: YES☐ NO☐

I GIVE RIALTO UNIFIED SCHOOL DISTRICT PERMISSION TO GIVE HEALTH INFORMATION TO NECESSARY PERSONNEL: YES☐ NO☐

THE FOLLOWING PEOPLE ARE AUTHORIZED TO BE CALLED AND TO PICK UP MY CHILDREN IN CASE OF AN EMERGENCY OR ILLNESS:
(Must be 18 years of age or older and must show a valid picture identification)

NAME	RELATION TO STUDENT	TELEPHONE
NAME	RELATION TO STUDENT	TELEPHONE
NAME	RELATION TO STUDENT	TELEPHONE
NAME	RELATION TO STUDENT	TELEPHONE

PLEASE CHECK WHICH OF THE FOLLOWING APPLIES TO THE STUDENT (MUST MARK ONE):

___ Living in a single family home/apartment/duplex etc.(200)

___ Living in a shelter(100)

___ Licensed Children's Institution/Group Home(220)

___ Living in a campground, park or car(130)

___ Living in a hotel or motel(110)

___ Unaccompanied Youth(20)

___ Kinship or Foster care placement(210)

___ Due to economic hardship, loss of housing, or similar reason, living with friends or relatives(120)

Please explain:_____
(For example: Rent a room)

***Federal Law Requirement*

IN CASE OF AN EMERGENCY AND I CANNOT BE REACHED:

I DO☐ I DO NOT ☐ AUTHORIZE SUCH ATTENTION AS MAY BE THOUGHT NECESSARY BY THE PHYSICIAN/MEDICAL ADVISOR IN CHARGE, PURSUANT TO THE PROVISIONS OF SECTION 49407 OF THE EDUCATION CODE OF CALIFORNIA AND SECTION 25.8 OF THE CIVIL CODE OF CALIFORNIA. I ALSO REALIZE THAT IN CERTAIN CIRCUMSTANCES, THE LOCAL POLICE OR AMBULANCE TRANSPORTATION MAY BE NECESSARY TO ENSURE EMERGENCY TREATMENTS.

X_____

SIGNATURE OF PARENT /LEGAL GUARDIAN DATE