



RIALTO UNIFIED SCHOOL DISTRICT
DISTRICT REGISTRATION CENTER
EARLY ED: State Preschool Enrollment
260 S. Willow Ave., Rialto CA 92376
(909) 873-4300 Fax: (909) 873-4301
EMAIL: REGISTRATIONS@rialto.k12.ca.us



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.

*****APPOINTMENT SUGGESTED, BUT WALK-INS WELCOME*****

- 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- Utility bill dated within the last 30 days.
- Photo I.D. for the parent/guardian



RIALTO UNIFIED SCHOOL DISTRICT DISTRICT REGISTRATION CENTER

260 South Willow Avenue, Rialto CA 92376
(909) 873-4300 Fax: (909) 873-4301
EMAIL: REGISTRATIONCENTER@rialto.k12.ca.us



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 EMPLOYER

DATE

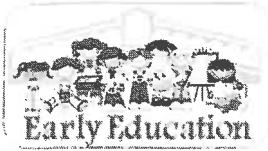
OFFICE USE ONLY

Information obtained by:

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

Notes: _____

Date: _____ Verified by: _____



RIALTO UNIFIED SCHOOL DISTRICT
DISTRICT REGISTRATION CENTER
EARLY EDUCATION

260 South Willow Avenue, Rialto CA 92376
(909) 873-4300 Fax: (909) 873-4301
EMAIL: REGISTRATIONCENTER@rialto.k12.ca.us



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

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) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	/ /
HEPATITIS B	/ /	/ /	/ /	/ /	/ /
VARICELLA (CHICKENPOX)	/ /	/ /	/ /	/ /	/ /

SCREENING OF TB RISK FACTORS (listing on reverse side)

- Risk factors not present; TB skin test not required.
- Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have have not reviewed the above information with the parent/guardian.

Physician: _____
Address: _____
Telephone: _____

Date of Physical Exam: _____
Date This Form Completed: _____
Signature _____

Physician Physician's Assistant Nurse Practitioner



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 Last 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: _____

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

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

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> 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	WHAT ARE USUAL EATING HOURS?
	LUNCH	BREAKFAST _____
	DINNER	LUNCH _____
		DINNER _____

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?
--------------------	----------------------

IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE?*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

WORD USED FOR 'BOWEL MOVEMENT'*	WORD USED FOR URINATION*
---------------------------------	--------------------------

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:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> 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:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> 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

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

Riverside

ZIP CODE

92501

AREA CODE/TELEPHONE NUMBER

(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)

Preschool

(PRINT THE ADDRESS OF THE FACILITY)

(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
 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)

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

Student Information

Legal Last Name, Legal First Name, Legal Middle Name, Grade, Retained?, Also Known As, Social Security Number, Address, Apt./Space, City, Zip Code, Mailing address, if different, Phone Number, Date of Birth, Place of Birth, Sex (Male/Female)

Office Use Only: School Year, Grade, Date, Student Number, School Assigned, Class Assigned, Start Date, Teacher, Birth Verification, Enter Code, Address Verification, Staff Signature

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

Name of Person Enrolling Student, Parent 1: Name of Legal Father, Parent 2: Name of Legal Mother, Relationship checkboxes (Mother, Father, Foster Parent, Legal Guardian, Caregiver, Lives with/Not in Home)

Children Living in the Home table with columns: 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

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.

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)

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

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.



**RIALTO UNIFIED SCHOOL DISTRICT
DISTRICT REGISTRATION CENTER
EARLY EDUCATION**



260 South Willow Avenue, Rialto CA 92376
(909) 873-4300 Fax: (909) 873-4301
WWW.REGISTRATIONCENTER@rialto.k12.ca.us

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

<u>Office Use Only</u>	
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)

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.

Medications:

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: _____

***Federal Law Requirement

(For example: Rent a room)

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 _____