



**Rialto Unified School District
Parent/Guardian Enrollment Checklist
(TK - Kindergarten)**

- Immunization Record
- *TB Test – must include results
- Proof of Date of Birth (birth certificate, certified birth record, baptismal certificate, passport, or affidavit)
- Current address verification in parent/guardian name (Utility bill, official mail, rental/lease agreement or payment receipts, property tax receipt, pay stubs, voter registration, or affidavit no more than 30 days old)
- Identification of the enrolling parent/guardian
- Proof of Dental Exam (Only for kindergarten)
- Current/Signed** IEP if the student is receiving special education services

** Applies to all students (TK – 12th Grade) who seek admission to a California school for the first time or have been away from the U.S. for more than 12 months*

Enrollment Center

260 South Willow Avenue, Rialto, CA 92376

Phone: 909-873-4300 Fax: 909-873-4301

email: enrollmentcenter@rialtousd.org

RIALTO UNIFIED SCHOOL DISTRICT ENROLLMENT FORM

STUDENT INFORMATION (please use blue or black ink)						OFFICE USE ONLY	
Legal Last Name		Legal First Name		Legal Middle Name			Notes: <hr/> <hr/> Grade: _____ Date: _____ Student #: _____ School of Residence: _____ School Assigned: _____ Start Date: _____ Teacher/Counselor: _____ Classroom/AM or PM: _____ Birth Verification: _____ P.O.B: _____ Enter Code: _____ Reason: <input type="checkbox"/> Overflow <input type="checkbox"/> Inter/Intra <input type="checkbox"/> Other: _____ Address Verification: <input type="checkbox"/> Utility/Rent Receipt <input type="checkbox"/> Affidavit of Residence <input type="checkbox"/> Other: _____ <input type="checkbox"/> McKinney Vento <input type="checkbox"/> Foster 4-digit zip: _____ Enrolled by: <hr/>
Grade	Retained? If yes, what grade?	Also Known As (other names used)					
Address		Apt./Space	<input type="checkbox"/> Rialto <input type="checkbox"/> San Bernardino <input type="checkbox"/> Colton <input type="checkbox"/> Fontana <input type="checkbox"/> Other: _____		Zip Code		
Mailing address, if different		Apt./Space	<input type="checkbox"/> Rialto <input type="checkbox"/> San Bernardino <input type="checkbox"/> Colton <input type="checkbox"/> Fontana <input type="checkbox"/> Other: _____		Zip Code		
Primary Phone Number		Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Preferred Language of Correspondence			
ETHNICITY (Please select one) Is your child Hispanic or Latino? <input type="checkbox"/> Yes, Hispanic or Latino <input type="checkbox"/> No, Not Hispanic or Latino		RACE (Please select all that apply) <input type="checkbox"/> American Indian or Alaska Native (Origins in North, Central or South America) <input type="checkbox"/> African American <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino/Filipino American <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Hmong <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Samoan <input type="checkbox"/> Tahitian <input type="checkbox"/> Vietnamese <input type="checkbox"/> White (Origins in Europe, North Africa, or the Middle East)					
FAMILY INFORMATION (If there is a custody/restraining order for your child, please provide copy)							
Name of Person Enrolling Student		Relationship to student <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Caregiver <input type="checkbox"/> Foster Parent <input type="checkbox"/> Legal Guardian		Home Phone			
Name of Legal Mother		<input type="checkbox"/> Lives with <input type="checkbox"/> Not in the home		Work Phone			
Name of Legal Father		<input type="checkbox"/> Lives with <input type="checkbox"/> Not in the home		Home Phone			
				Work Phone			
CHILDREN LIVING IN THE HOME							
Name		Date of Birth		School			
Name		Date of Birth		School			
Name		Date of Birth		School			
Name		Date of Birth		School			
PREVIOUS SCHOOL INFORMATION (List last school first)							
Name of School		City	State	Grade	School Year		
Name of School		City	State	Grade	School Year		
Has the student attended a Rialto USD school? <input type="checkbox"/> Yes <input type="checkbox"/> No (ex: Preschool)		If yes, name school:		Grade	School Year		
PARENT EDUCATION LEVEL			PRIOR SPECIAL EDUCATION PROGRAMS				
The California State Department of Education requests information regarding the highest level of education completed by the enrolling parent/guardian. Please check for both parents.			Please provide the following information for student placement in a special service or program:				
Mother/Guardian 1 <input type="checkbox"/> Not a high school graduate <input type="checkbox"/> High school graduate <input type="checkbox"/> Some College <input type="checkbox"/> College graduate <input type="checkbox"/> College degree from a 4 year university with additional coursework in graduate school			<input type="checkbox"/> My child has NOT participated in a special program <input type="checkbox"/> My child has had a special education evaluation				
Father/Guardian 2 <input type="checkbox"/> Not a high school graduate <input type="checkbox"/> High school graduate <input type="checkbox"/> Some College <input type="checkbox"/> College graduate <input type="checkbox"/> College degree from a 4 year university with additional coursework in graduate school			My child has participated in the following services: <input type="checkbox"/> Specialized Academic Instruction (ex. RSP/SDC) <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Adaptive Physical Education <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Other: _____				

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.

Parent/Guardian Signature: _____ Date: _____

Home Language Survey

Student Name: _____

Date of Birth: _____

Grade: _____

Directions to Parents and Guardians:

The California *Education Code* contains legal requirements which direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with these requirements. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered. If an error is made completing this home language survey, you may request correction before your student's English proficiency is assessed.

1. Which language did your child learn when they first began to talk? _____
2. Which language does your child most frequently speak at home? _____
3. Which language do you (the parents and guardians) most frequently use when speaking with your child? _____
4. Which language is most often spoken by adults in the home? _____
(parents, guardians, grandparents, or any other adults)

Please sign and date this form in the spaces provided below, then return this form to your child's teacher. Thank you for your cooperation.

Signature of Parent or Guardian: _____ Date: _____

OFFICE USE ONLY

School: _____ Reviewed by: _____
Enrollment Staff

Sent to Multilingual Programs on: _____

Received by MLP/LAC on: _____



Rialto Unified School District

Child Welfare and Attendance McKinney-Vento Questionnaire

STUDENT'S NAME	DATE OF BIRTH	PREVIOUS SCHOOL
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PLEASE LIST ALL CHILDREN CURRENTLY LIVING WITH YOU

NAME	DATE OF BIRTH	SCHOOL
NAME	DATE OF BIRTH	SCHOOL
NAME	DATE OF BIRTH	SCHOOL
NAME	DATE OF BIRTH	SCHOOL
NAME	DATE OF BIRTH	SCHOOL
NAME	DATE OF BIRTH	SCHOOL

THE ANSWERS TO THE FOLLOWING QUESTIONS WILL HELP DETERMINE IF YOUR STUDENT MAY BE ELIGIBLE TO RECEIVE ADDITIONAL SUPPORT SERVICES UNDER THE MCKINNEY-VENTO ACT. PLEASE CHECK ALL THAT APPLY.

Student is living in **SHARED HOUSING** due to **economic hardship and/or a crisis driven situation** YES NO
(i.e. domestic violence, abuse, rotating homes, living in one room, garage, etc.)

Student is living in **INADEQUATE HOUSING** not originally designated for sleeping YES NO
(i.e. cars, parks, campers, trailer parks, abandoned buildings, etc.)

Student is **TEMPORARILY** living in **HOTELS/MOTELS** YES NO

Student is **TEMPORARILY** living in **EMERGENCY OR TRANSITIONAL SHELTERS** YES NO

Student is living in **SUBSTANDARD HOUSING** YES NO
(i.e. damaged or destroyed property, basic utilities are unavailable on the premises, lacks basic functional parts, etc.)

Student is living with someone **OTHER** than his/her parent(s) or legal guardian YES NO

Student is considered a **MIGRANT STUDENT** YES NO
(i.e. parent/guardian works in agricultural/fishing industries, requiring them to move according to various seasons)

**IF YOU MARKED 'YES' TO ANY OF THE ABOVE QUESTIONS, PLEASE COMPLETE THE REMAINDER OF THIS FORM.
 IF YOU ANSWERED 'NO' TO ALL THE QUESTIONS, YOU MAY STOP HERE.**

- Student has an active **IEP, 504 plan, or SST**. Please specify: _____
- Attendance concerns *(refusing and/or afraid to go to school)*
- Student is in need of or interested in **counseling services, tutoring services, afterschool programs, and/or mentorship programs**. Please specify: _____
- Behavior concerns. Please specify: _____
- Medical concerns. Please specify: _____

BY SIGNING BELOW, THE PARENT/GUARDIAN CERTIFIES THAT THE INFORMATION PROVIDED IS CORRECT AND ACCURATE

PRINT NAME	SIGNATURE	DATE
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PLEASE TURN DOCUMENT TO VIEW FURTHER INFORMATION REGARDING THE MCKINNEY-VENTO ACT



Rialto Unified School District

Child Welfare and Attendance McKinney-Vento Questionnaire

Under the McKinney-Vento act, your child(ren) may be entitled to:

- immediate school enrollment and full participation in all school activities for eligible children, even when records normally required for enrollment are not available
- remain in their school of origin (the school the student attended when permanently housed or the school in which the student was last enrolled), when in the child's or youth's best interest to do so
- transportation to and from the school of origin at the request of the parent or guardian
- provision of services comparable to services offered to other students in the school, including Title I services or similar state or local programs, educational programs for children with disabilities, and educational programs for English learners; career and technical education; programs for gifted and talented students; and school nutrition programs

If you have any questions regarding these rights, please contact your school site's homeless youth representative.

Krystal Rojas • Brenda Salas
McKinney-Vento and Foster Youth Liaisons

Per State Law (AB 16) "A child will not be removed from the child's family solely because the child's family is experiencing homelessness per Section 48851 to the Education Code.

OFFICE USE ONLY

<u>DATE OF ENROLLMENT</u>	<u>STUDENT ID NUMBER</u>	<u>SCHOOL OF ENROLLMENT</u>	<u>GRADE</u>

Student Name: _____



Rialto Unified School District

Custody Issues

Parent Disputes over Custody in School Setting

Parents may try to use the school as a forum for disputing custody matters. If needed, the school district may consider including the following form in their annual notification to parent and legal guardians.

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 such situation become a disruption to the school, law enforcement will be contacted and an officer requested to intervene. Unless Educational Rights have been revoked, both parents have access to student records.

Parents are asked to make every attempt not to involve school sites 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.

I have read and understand the above statement.

Parent/Guardian Signature 1

Date

Parent/Guardian Signature 2

Date

Office use only:

Date Received: _____

Home School: _____

Notification placed on Synergy: _____

Document(s) uploaded to Synergy: _____



RIALTO UNIFIED SCHOOL DISTRICT HEALTH SERVICES

815 S. Willow Ave., Rialto, CA 92376 • Tel (909) 820-8150 • Fax (909) 820-8151

STUDENT HEALTH HISTORY

Student Name: _____ Date of Birth: _____

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 & Results: _____
Treatment Required: Yes No If YES, Explain: _____
- Requires "Specialized Health Procedure." **Explain under "Comments."**

Comments / Other Conditions / Medications: _____

Parent/Guardian Signature: _____

Date: _____

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31 of his/her first year in public school. A California licensed dental professional operating within his scope of practice must perform the check-up and fill out Section 2 of this form. If your child had a dental check-up in the 12 months before he/she started school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:	Child's race/ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other _____ <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown		

Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box.

Assessment Date:	Caries Experience (Visible decay and/or fillings present) <input type="checkbox"/> Yes <input type="checkbox"/> No	Visible Decay Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Urgency: <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) <input type="checkbox"/> Urgent care needed (pain, infection, swelling or soft tissue lesions)
<div style="display: flex; justify-content: space-between; margin-top: 10px;"> _____ _____ _____ </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <i>Licensed Dental Professional Signature</i> <i>CA License Number</i> <i>Date</i> </div>			

Section 3: Waiver of Oral Health Assessment Requirement

To be filled out by parent or guardian asking to be excused from this requirement

Please excuse my child from the dental check-up because: (Check the box that best describes the reason)

- I am unable to find a dental office that will take my child's dental insurance plan.
 My child's dental insurance plan is:
 Medi-Cal/Denti-Cal Healthy Families Healthy Kids Other _____ None
- I cannot afford a dental check-up for my child.
- I do not want my child to receive a dental check-up.
- Optional: other reasons my child could not get a dental check-up: _____

If asking to be excused from this requirement: ► _____
Signature of parent or guardian
Date

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school.

Return this form to the school no later than May 31 of your child's first school year.
 Original to be kept in child's school record.

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last First Middle BIRTH DATE—Month/Day/Year

ADDRESS—Number, Street City ZIP code SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	/ /
Physical Examination	/ /
Dental Assessment	/ /
Nutritional Assessment	/ /
Developmental Assessment	/ /
Vision Screening	/ /
Audiometric (hearing) Screening	/ /
TB Risk Assessment and Test, if indicated	/ /
Blood Test (for anemia)	/ /
Urine Test	/ /
Blood Lead Test	/ /
Other	/ /

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DtaP/DTP/DTTd (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER (e.g., TB Test, if indicated)					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER (optional) and RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

- Examination shows no condition of concern to school program activities.
- Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: (please explain)

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

Please check this box if you **do not** want the health examiner to fill out Part III.

Signature of parent or guardian Date

Name, address, and telephone number of health examiner

Signature of health examiner Date

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.

PARENTS' GUIDE TO IMMUNIZATIONS REQUIRED FOR SCHOOL ENTRY



Starting July 1, 2019

Students Admitted at TK/K-12 Need:

- **Diphtheria, Tetanus, and Pertussis (DTaP, DTP, Tdap, or Td) — 5 doses**
(4 doses OK if one was given on or after 4th birthday.
3 doses OK if one was given on or after 7th birthday.)
For 7th-12th graders, at least 1 dose of pertussis-containing vaccine is required on or after 7th birthday.
- **Polio (OPV or IPV) — 4 doses**
(3 doses OK if one was given on or after 4th birthday)
- **Hepatitis B — 3 doses**
(Not required for 7th grade entry)
- **Measles, Mumps, and Rubella (MMR) — 2 doses**
(Both given on or after 1st birthday)
- **Varicella (Chickenpox) — 2 doses**

These immunization requirements apply to new admissions and transfers for all grades, including transitional kindergarten.

Students Starting 7th Grade Need:

- **Tetanus, Diphtheria, Pertussis (Tdap) — 1 dose**
(Whooping cough booster usually given at 11 years and up)
- **Varicella (Chickenpox) — 2 doses**
(Usually given at ages 12 months and 4-6 years)

In addition, the TK/K-12 immunization requirements apply to 7th graders who:

- previously had a valid personal beliefs exemption filed before 2016 upon entry between TK/Kindergarten and 6th grade
- are new admissions

Records:

California schools are required to check immunization records for all new student admissions at TK/Kindergarten through 12th grade and all students advancing to 7th grade before entry. Parents must show their child's Immunization Record as proof of immunization.



Type content for your school or local enrollment assistance

Enroll. Get Care. Renew. Health Coverage All Year Long

Health Coverage Options

Medi-Cal:

- ▶ Children—regardless of immigration status—foster youth, pregnant women, and legally present individuals—including those with DACA status—may be eligible for no- or low-cost Medi-Cal.
- ▶ Medi-Cal covers immunizations, checkups, specialists, vision and dental services, and more for children and youth at no- or low-cost.
- ▶ Medi-Cal enrollment is available year-round.

Covered California:

- ▶ Covered California is where legal residents of California can compare quality health plans and choose the one that works best for them.
- ▶ Based on income and family size, many Californians may qualify for financial assistance.
- ▶ Enroll during Open Enrollment or any time you experience a life-changing event, like losing your job or having a baby. You have 60 days from the event to complete enrollment.

Undocumented Families visit: www.allinforhealth.org/resources#Undocumented
 Immigration status information is kept private, protected, and secure. It will not be used by any immigration agency to enforce immigration laws, but only to determine eligibility for health programs.

You and your family may qualify for financial help:

Household Size	If 2016 household income is less than...		If 2016 household income is between...
	\$16,394	\$31,600	
1	\$16,394	\$31,600	\$16,395 – \$47,080
2	\$22,107	\$42,613	\$22,108 – \$63,720
3	\$27,820	\$53,625	\$27,821 – \$80,360
4	\$33,534	\$64,638	\$33,535 – \$97,000
5	\$39,247	\$75,650	\$39,248 – \$113,640
6	\$44,960	\$86,662	\$44,961 – \$130,280
▶	Adults may be eligible for Medi-Cal	Children may be eligible for Medi-Cal	May be eligible for financial help to purchase insurance through Covered California

Enroll.

Three ways to enroll in Medi-Cal and Covered California:

- www.coveredca.com
- 1(800) 300-1506
- Find in-person help: www.coveredca.com/get-help/local/

Get Care.

- ▶ Find a primary care doctor in your network.
- ▶ Schedule an annual checkup for you and your family.
- ▶ Make sure to take your child to the dentist.
- ▶ Pay your monthly premium if your plan requires it.

Renew.

- ▶ Medi-Cal must be renewed every year. Medi-Cal will mail renewal packet. Complete and return. For help, contact your local Medi-Cal office or call 211.
- ▶ Health plans through Covered California must be renewed every year. Renewal information will be mailed at the end of the year, or contact Covered California at 1 (800) 300-1506.

For more information go to: www.allinforhealth.org

April 2016



RIALTO UNIFIED SCHOOL DISTRICT • HEALTH SERVICES • 815 S. WILLOW AVENUE, RIALTO, CA 92376 • TEL: (909) 820-8150

Possible Referrals: If you have a personal health care provider, please feel free to use them. *We do not endorse any specific health care provider.*
Posibles recomendaciones: Si usted tiene su propio dentista u optometrista por favor usarlos. *Nosotros no endosamos ningún médico específico.*

DENTAL CARE

DENTAL REFERRAL SERVICE

(800) 511-8663 or (800) 322-6384



FIRST 5 DENTAL
(5 years old and younger)
(800) 722-4597

DENTI-CAL

(800) 322-6384

LOMA LINDA SCHOOL OF DENTISTRY

(Pediatric Dental Clinic)

Loma Linda (909) 558-4689

INLAND FAMILY COMMUNITY HEALTH CENTER

(For Dental Office)

665 North 'D' Street
San Bernardino (909) 708-8168

GOLDEN WEST DENTISTRY

9922 Sierra Ave.
Fontana (909) 822-4800

BR DENTAL

(Next to Clinica Medica Familiar)

Dr. Kwon, DDS
436 S. Riverside Ave.
Rialto (909) 874-5200

DR. DAVID A. NEWSHAM, DDS

1735 N. Riverside Ave.
Rialto (909) 820-9081



MEDICAL CARE

SAC HEALTH SYSTEM

To schedule an appointment
(909) 693-2163

ONTARIO DEPT. OF PUBLIC HEALTH

(909) 458-9447

COUNTY OF SAN BERNARDINO DEPT. OF PUBLIC HEALTH

351 N Mt. View Ave.
San Bernardino (800) 722-4777

BLOOMINGTON COMMUNITY HEALTH CENTER

18601 Valley Blvd.
Bloomington (909) 546-7520



MOMMY AND ME

790 E. Foothill Blvd.
Rialto (909) 546-7135



GOLDEN SHORE MEDICAL

790 E. Foothill Blvd.
Rialto (909) 546-7135

190 E. Highland Ave.

San Bernardino (909) 882-4788

INLAND FAMILY COMMUNITY HEALTH CENTER

(For Medical Office)

665 North 'D' Street
San Bernardino (909) 708-8158

ARROWHEAD REGIONAL MEDICAL CENTER -

MEDICAL MOBILE CLINIC

For clinic location and/or appointment
(909) 520-1207

VISION EXAMS

FREESTONE OPTOMETRIC CENTER

Dr. Gary M. Freestone, OD
1850 N. Riverside Ave., Suite 220
Rialto (909) 875-1144



RIALTO OPTOMETRIC CENTER

Dr. Bernard Rubin, OD
1850 N. Riverside Ave., Suite 210
Rialto (909) 421-3030

COLTON OPTOMETRIC CENTER

Dr. Thomas B. Law, OD
190 W. H St., Suite 105
Colton (909) 825-9044



COUNSELING SERVICES



MESA COUNSELING SERVICES

850 E. Foothill Blvd.
Rialto (909) 421-9358

BILINGUAL FAMILY COUNSELING SERVICES

317 West 'F' Street
Ontario (909) 986-7111

LOMA LINDA UNIVERSITY

MARITAL & FAMILY THERAPY CLINIC
164 W. Hospitality Ln., Suite 15
San Bernardino (909) 722-4777

SOUTH COAST COMMUNITY SERVICES

San Bernardino County
(877) 527-7227



COVERED CALIFORNIA
(800) 300-1506
www.coveredca.com



IEHP
(800) 720-4347
www3.iehp.org



MEDI-CAL
(877) 410-8829
www.C4Yourself.com



SAN BERNARDINO COUNTY
TRANSITIONAL ASSISTANCE DEPARTMENT
1175 W. Foothill Blvd.
Rialto (877) 410-8829