Office Use		
Child's Age	Fam Size	Rank

GUSD STATE PRESCHOOL PROGRAM
2018-2019

240 Swanston Lane
Gilroy CA 95020
(408) 847-7835
Lupe Vela

Appointment

Date: _____ **Time:** _____

Enrollment is not on a first-come basis.

GUSD offers a state preschool program. Families must qualify based on their income. **Priority for enrollment of eligible students is based on the following** (Must be a Gilroy resident):

- Age eligible children who are neglected or abused children who are recipients of child protective services, or who are at risk of being neglected, abused, or exploited upon written referral from a legal, medical, or social service agency.
- Children who turn **four (4) years old on or before December 1, 2018** in income eligibility order using the California Department Education (CDE) income ranking chart. (see chart below)
- Children who turn **three (3) years old on or before December 1, 2018** and are fully potty trained depending on space availability.

State Preschool Income Eligibility Guidelines

Family Size	1-2	3	4	5	6	7	8
Maximum Gross Monthly Income	4,894	5,270	5,922	6,870	7,817	7,995	8,172

If you do not qualify for our program, you may contact Community Child Care of Santa Clara (4C's) (408)487-0749 online: http://www.4c.org/parent/looking/index.html. 4C's is a member of the California Child Care Resource and Referral network and the National Association of Child Care Resource and referral Agencies. They should be able to provide you with a referral of all the preschools in the area.

ALL DOCUMENTATION REQUIRED AT THE TIME OF YOUR APPOINTMENT
INCOMEPLETE APPLICATIONS WILL NOT BE ACCEPTED

- ☐ **Proof of income for all individuals counted in the family size:** Pay stubs representing the **past 30 days from your appointment date.** Ensure that the pay stubs are **recent and that the dates are consecutive.** Missing stubs will **NOT** be accepted.
  ◊ Weekly Pay – 4 pay stubs ◊ Bi-Weekly Pay – 2 stubs ◊ Twice a month – 2 pay stubs ◊ Monthly pay – 1 stub
- ☐ Families with **varying income** (migrant, agricultural, or seasonal work) must submit income verification for the past **12 consecutive months.** Missing paystubs will **NOT** be accepted. Payroll summary for the past 12 months are acceptable.
- ☐ Proof of any other income (unemployment, child support, TANF, cash aid, disability, social security, etc.) for the **past 30 days**
- ☐ Employment Verification
- ☐ Self-employed parents must submit: copy of most recent tax returns with a statement of current estimated income for tax purpose, a letter from the source of income (i.e customers), other business records like ledgers or business logs, profit & loss, etc.
- ☐ Physical Exam (done August 2016 or after) **May be pending for registration but must be turned in before the 1st day of school**
- ☐ Immunization Record- **Children will not be admitted without required immunizations or TB assessment**
  - TB Test- The child is to be evaluated for risk factors for tuberculosis as part of his or her medical assessment. A child is only required to have a Mantoux skin test for tuberculosis if determined to be necessary by a physician based on the child's risk factors for tuberculosis
- ☐ Copy of birth certificates of **all your children in the household under the age of 18 years old**
- ☐ Proof of address: rental receipts or agreements, contracts, utility bills
- ☐ Attached forms filled out

If applicable

- ☐ Individualized Education Program (IEP)
- ☐ Records of Foster Care placements, legal guardianship

I have been explained the enrollment process, I understand that missing documentation or an incomplete application will NOT be accepted and will have to reschedule my appointment.
_____ **Initials.**

Rev-1/16/18

Gilroy Unified School District

State Preschool Program ONLY

2018-2019

Submission of this application is not a guarantee of enrollment and it is not possible to determine how long you might wait for services. Program enrolls the most eligible children first based on age, income and admission priorities established by the California Department of Education.

CHILD'S INFORMATION

Child's legal First Name	Middle Name	Last Name

Name usually used for child if different	Gender F M	Child's Date of Birth	City of Birth

County of Birth	Ethnicity	How did you hear about our program?

HOME LANGUAGE SURVEY

1. What language did this student learn when first beginning to talk?	2. What language do you use most frequently to speak to this student?
3. What language does this student most frequently use at home?	4. What is the preferred language for your correspondence?

FAMILY INFORMATION

Parent A Marital Status: _____ **Relationship to child:** ☐Parent ☐Grandparent ☐Foster ☐Guardian ☐Other _____	Parent A	Date of Birth	Gender F M
	Ethnicity	Languages (s) Spoken	Highest Education Level Completed:
Parent B Living in the home: ☐Yes ☐No **Relationship to child:** ☐Parent ☐Grandparent ☐Foster ☐Guardian ☐Other _____	Parent B	Date of Birth	Gender F M
	Ethnicity	Languages (s) Spoken	Highest Education Level Completed:

Home Address	Mailing Address (if different from home)	Best number to call	Family Size
_____	_____	Alt phone number	
_____	_____	email	

ELIGIBILITY INFORMATION

Parent A Source of Income	Parent A Monthly Income	Parent B Source of Income	Parent B Monthly Income

CHILD'S NEED INFORMATION

1. Does your child have a special need? _____ (if no, please go to question #5)
2. Type of special need _____
3. Has the child been professionally diagnosed? _____ (if yes, at what age _____? By whom? _____
4. Is the child receiving special services?
5. In your opinion, does your child have a special need that has not yet been diagnosed? If yes, please explain: _____

_____

SITE REQUESTED

Preferred preschool site/teacher: _____ This is a 3 hour program. Sessions times vary by site. ☐AM ☐PM	**I UNDERSTAND THAT MY REQUEST IS TAKEN INTO CONSIDERATION BUT IT IS NOT GUARANTEED_____ initials**

Certification: *I declare under penalty of perjury that the above information is complete and true to the best of my knowledge. I understand my eligibility will be based upon information given here and that documentation will be required prior to enrollment.*

Parent/Guardian Signature	Date

PERSONAL RIGHTS

Child Care Centers

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

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

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

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

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily 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
2580 N First Street Suite 300

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
San Jose	95131	(408) 324-2148

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)
GUSD Preschool Program	240 Swanston Lane Gilroy CA 95020

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(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: 2580 N First Street Suite 300

   Licensing Office Telephone #: San Jose CA 95031 (408) 324-2148

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.

GUSD Preschool Program
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

Gilroy Unified School District
CONFIDENTIAL

Student's Name: _____ Date of Birth: _____

What is your Child's Ethnicity? (***Please Check One***)

□Hispanic or Latino (A person of Cuba, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)

□Not Hispanic or Latino

What is your child's race? (Please check up to five racial categories)

The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be.

□American Indian or Alaskan Native (100) (persons having origins in any of the original people of North, Central or South America)

□Chinese (201)

□Japanese (202)

□Korean (203)

□Vietnamese (204)

□Asian Indian (205)

□Laotian (206)

□Cambodian (207)

□Hmong (208)

□Other Asian (299)

□Hawaiian (301)

□Guamanian (302)

□Samoan (303)

□Tahitian (304)

□Other Pacific Islander (399)

□Filipino/Filipino American (400)

□African American or Black (600)

□White (700) (persons having origins in any of the original peoples of Europe, North Africa, or the Middle East)

MOBILITY *(Required/Mandated)*

1. Circle the grade in which you are enrolling your child. P K 1 2 3 4 5 6 7 8 9 10 11 12

2. Child the grade when your child first entered/attended this district
   P K 1 2 3 4 5 6 7 8 9 10 11 12

3. What month and year did/will your child first attend a public school in California? Month _____Yr _____

   IF Your child was NOT born in the United States, please answer the question #4, #5, #6

4. When did/will your child first enter the United States? Month _____Yr _____

5. From what county did your child enter the United States? _____

6. When did/will your child first attend school in the United States? Month _____Yr _____

FIRST 5
SANTA CLARA COUNTY

ACKNOWLEDGMENT AND CONSENT

I, _____, as the parent, guardian or legally authorized
Parent name(s)

representative of _____
Child(ren)'s name(s)

have been informed and understand that FIRST 5 Santa Clara County may share confidential information about my family with other persons or agencies that work with FIRST 5 to plan and provide services to my family.

Participating agencies working with FIRST 5 to plan and provide services may include, but are not limited to: medical providers, the Behavioral Health Services Department, the Public Health Department, the Social Services Agency, Pre-school and Head Start Programs, the Regional Center, early education providers and other providers of early childhood services.

Each agency will only release or exchange confidential information or records to other participating agencies when the information may be relevant to the services to be provided or for evaluation purposes as explained below.

A separate authorization form is required for the release of medical information from a health care provider. I understand that I may be requested to sign other forms for the release of medical information.

I understand that FIRST 5 is required to conduct evaluations of the services they provide to my family. This requires collecting and analyzing information and data that may include confidential information about my family. I understand that this information will help improve services to families like mine and that no confidential information will be included in any public report.

FIRST 5 requires my permission to collect and analyze confidential information for evaluation purposes. Such information may be shared with FIRST 5 evaluators, partners and providers of early childhood services. Each agency understands that they must maintain the confidentiality of such information and can further disclose such information only as required by law or as authorized by a written consent to release the information. There are minimal risks to my family from sharing this information.

I give my permission to FIRST 5 and its evaluators and partners to collect and analyze my family's personal information for program evaluation purposes.

I understand that if I choose not to sign this Acknowledgment and Consent, my family will still receive services and for that purpose my name and address will be entered into the FIRST 5 database and will be available to the administrator of the database.

I also understand that I may cancel this consent at any time by writing to the Research and Evaluation Department, FIRST 5 Santa Clara County, 4000 Moorpark Avenue, Suite 200, San Jose, CA 95117. Cancellation of my permission will not affect any information that has already been collected.

This consent shall remain in effect for 10 years.

FIRST 5
SANTA CLARA COUNTY

ACKNOWLEDGMENT AND CONSENT
(continued)

I have read this form, or it has been fully explained to me, and I understand the provisions.

Parent(s), Legal Guardian or Legal Representative:

Print Name	Print Name
Signature	Signature
Relationship to Child(ren)	Relationship to Child(ren)

Child(ren)'s Name(s)

Date

GUSD Preschool Program
Name of Agency obtaining parent signature and holding original form

Lupe Vela
Name of Person obtaining parent signature

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

GUSD Preschool Program
FACILITY NAME

TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____
NAME

. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

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)

GUSD Preschool . This Child Care Center/School provides a program which extends from 3 : hrs
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m., 5 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: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ 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.

Child's Name: _____ Birthdate: _____ Male/Female School: GUSD-Preschool
Last, First month/day/year

Address_____ Phone: _____ Grade: Preschool
Street City Zip

Santa Clara County Public Health Department
TB Risk Assessment for School Entry

This form must be completed by a licensed health professional and returned to the child's school.

1. Was your child born in Africa, Asia, Latin America, or Eastern Europe?	❑ Yes ❑ No
2. Has your child traveled to a country with a high TB rate* (for more than a week)?	❑ Yes ❑ No
3. Has your child been exposed to anyone with tuberculosis (TB) disease?	❑ Yes ❑ No
4. Has a family member or someone your child has been in contact with had a positive TB test or received medications for TB?	❑ Yes ❑ No
5. Was a parent, household member or someone your child has been in close contact with, born in or traveled to a country with a high TB rate?*	❑ Yes ❑ No
6. Has another risk factor for TB (i.e. one of those listed on the back of this page)?	❑ Yes ❑ No

* This includes countries in Africa, Asia, Latin America or Eastern Europe. For travel, the risk of TB exposure is higher if a child stayed with friends or family members for a cumulative total of 1 week or more.

If YES, to any of the above, the child has an increased risk of TB infection and should have a TST/ IGRA.

All children with a positive TST/IGRA result must have a medical evaluation, including a chest X-ray. Treatment for latent TB infection should be initiated if the chest X-ray is normal and there are no signs of active TB. If testing was done, please attach or enter results below.

Tuberculin Skin Test (TST/Mantoux/PPD) Date given: Date read:	Induration _____ mm Impression: ❑ Negative ❑ Positive
Interferon Gamma Release Assay (IGRA) Date:	Impression: ❑ Negative ❑ Positive ❑ Indeterminate
Chest X-Ray (**required with positive TST or IGRA**) Date:	Impression: ❑ Normal ❑ Abnormal finding
☐ LTBI treatment (Rx & start date): ☐ Contraindications to INH or rifampin for LTBI	☐ Prior TB/LTBI treatment (Rx & duration): ☐ Offered but refused LTBI treatment

Providers, please check one of the boxes below and sign:

☐ Child has no TB symptoms, none of the above or other risk factors for TB and does not require a TB test.

☐ Child has a risk factor, has been evaluated for TB and is free of active TB disease.

_____ _____
Health Provider Signature, Title **Date**

Name/Title of Health Provider:

Facility/Address:

Phone number: **Fax number:**

GUSD Preschool Program
Employment Verification

Applicant:_____

The above named parent/guardian has applied for state preschool services with our agency. In order to determine the child care needs of this applicant, the following information is required. Please submit this form back to our office.

Authorization: I, hereby authorize for Gilroy Unified School District Preschool Program and its representatives to verify any and all information from my employer to determine my family eligibility during the certification process. I understand all information is strictly confidential. I hereby authorize my employer to release the information listed below:

Signature: _____ Date: _____

To be completed by Employment Representative

_____

Company Name Telephone

_____

Address Zip Code

Employee's Start Date: _____ Position: _____

Is employment temporary? _____ If yes, what is the expected termination date? _____

Employee gets paid? Hourly $ _____ Salary $ _____ Gross Monthly Income _____

Method of pay ☐Company Check ☐Personal Check ☐Other: _____

Pay Frequency ☐Weekly ☐BiWeekly ☐Twice a month ☐Monthly ☐Other: _____

Please indicate Work Schedule:

☐Split Shift ☐Part Time ☐Full Time

☐Variable Work Schedule

Minimum hours a week _____

Maximum hours a week _____

Monday	_____ to _____
Tuesday	_____ to _____
Wednesday	_____ to _____
Thursday	_____ to _____
Friday	_____ to _____
Saturday	_____ to _____
Sunday	_____ to _____

I affirm that to the best of my knowledge and belief the above statements are true. I understand the above information pertains to the employee's eligibility for state preschool services and is subject to review by the State of California Representatives.

_____ _____

Employer or Authorized Representative's Signature Date

_____ _____

Employer or Authorized Representative's Printed Name Title