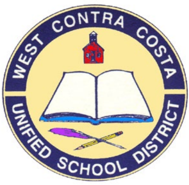


WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT
Office *of* Teaching, Learning & Leading
Early Learning Programs
1108 Bissell Avenue, Room 128
Richmond, California 94801
Telephone: (510) 307-4585
Email: preschool@wccusd.net

Sarah Breed
Executive Director,
Teaching, Learning & Leading

Olanrewaju Ajayi
Coordinator, Early Learning Programs

STATE PRESCHOOL PROGRAM

ADMISSION AGREEMENT

The Admission Agreement between the West Contra Costa Unified District and the parent/guardian of the child/children attending the State Preschool Program is considered contractual and binding.

The West Contra Costa Unified School District State Preschool Department's goal is to provide a safe, nurturing learning environment for students three to five years old. The program offered focuses on social emotional, physical and academic development to support students completing college.

State Preschool Department and the Adult Education Department assist parents with becoming their child's first teacher by providing on-going parenting classes that focus on the social, emotional and academic aspects of the child's development.

I, the parent of ______________________________________ who attends the
Child's name

A.M. / P.M. session at ______________________________agrees to the following:
Name of school

Reasons for discontinuing service
1. Child was picked up late four (4) times.
2. Child's behavior endangered him/herself or others.
3. Parent or guardian has not cooperated regarding the child's discipline needs.
4. Parent has 30 days from time of enrollment to provide current physical exam.

Parent acknowledges the rights of California Care Licensing
1. To enter, inspect a child care facility with or without advance notice at any time.
2. To interview children or staff, and to inspect and audit child or facility records without prior consent.
3. To observe the physical condition of children, including conditions which could indicate abuse, neglect, or inappropriate placement and to have a licensed medical professional physically examine the children.

Additional information about these topics can be found in the State Preschool Parent Handbook

I have read, understood, and agree to follow the rules and regulations of the WCCUSD State Preschool Program.

______________________________________ ________________________
Parent Signature Date

I have given a copy of this admission agreement to the parent/guardian of the student.

______________________________________ ________________________
WCCUSD Early Learning Programs Staff Date

Community Resources

- ❐ POISON CONTROL HOT LINE 800-876-4766
  INFORMATION ON TOXIC SUBSTANCES
- ❐ CHILD CARE SOLUTIONS 510-412-9200
  COUNSELING, REFERRALS, CLASSROOM ASSISTANCE FOR TEACHERS
- ❐ BATTERED WOMEN'S HOT LINE 1-888-215-5555
  REFERRALS FOR SHELTER COUNSELING
- ❐ RAPE CRISIS CENTER 800-670-7273
  REFERRALS FOR COUNSELING HELP
- ❐ RICHMOND FOOD PANTRY 510-235-9732
  FOOD - TUES & FRI. 12 – 3 P.M.
- ❐ SAN PABLO FOOD PANTRY 510-232-0258
  FOOD – MON & WED. 9:00 – 11 A.M.
- ❐ SALVATION ARMY 510-262-0500
  FOOD BANK, CLOTHING, - REQUIRES REFERRAL FROM SOCIAL WORKER – TUES. & FRI. 9 – 10:30 A.M.
- ❐ BAY AREA RESCUE MISSION 215-4555, 215-4884, 215-4860, 215-4868
  CLOTHING, HOUSING, MEALS
- ❐ RICHMOND SOUPER CENTER 510-233-2141
  165 22ND ST., RICHMOND, 10 A.M. – 2ND & 4TH TUES., & EVERY 3RD FRI., ALSO HAS DRUG & ALCOHOL PROGRAMS
- ❐ CHILDREN'S PROTECTIVE SERVICES SOCIAL SERVICES 510-262-7700
  INFORMATION & REFERRAL FOR FAMILIES IN CRISIS & NEED
- ❐ CRISIS CENTER, GRIEF COUNSELING 800-837-1818
- ❐ CRISIS & SUICIDE INTERVENTION 800-833-2900
- ❐ RUBICON 510-235-1516
  EMPLOYMENT & TRAINING SERVICE
- ❐ BAY AREA LEGAL AID 510-233-9954
  LOW INCOME RESIDENTS CAN GET SERVICE
- ❐ PARKS & RECREATION 510-620-6793
  AFTER SCHOOL PROGRAMS, SUMMER CAMPS
- ❐ BERKELEY HUMANE SOCIETY 510-845-7735
  PET ADOPTION, STRAY ANIMAL PICK-UP
- ❐ FIRE DEPARTMENT ADMINISTRATIVE OFFICE 510-307-8031
  EMERGENCY INFORMATION, CLASSROOM PRESENTATIONS
- ❐ POLICE DEPARTMENT ADMINISTRATIVE OFFICE 510-620-6656
  CLASSROOM PRESENTATION, EMERGENCY INFORMATION
- ❐ MAIN BRANCH LIBRARY 510-620-6561
  EDUCATIONAL, STORY HOUR, MOBILE LIBRARY
- ❐ EMPLOYMENT SERVICES/SOCIAL SERVICES 510-262-7703
  HELP/REFERRALS
- ❐ YOUTH CRISIS 800-843-5200
  HOT LINE REFERRAL SERVICE

Community Resources

- ❒ LAO FAMILY COMMUNITY DEVELOPMENT 510-215-1220
  REFERRALS/COUNSELING
- ❒ FAMILIAS UNIDAS COUNSELING CENTER 510-412-5930
  TRANSLATING, JOB REFERRALS, FOOD, COUNSELING
- ❒ CC CHILD CARE COUN 510-758-5439
  PARENTING CLASSES & CHILD CARE REFERRALS
- ❒ MENTAL HEALTH CENTER/WCOUNTY 1-925-957-5126
  COUNSELING, TRANSLATING SERVICES
- ❒ RICHMOND HEALTH CENTER 510-231-1350
  HEALTH CARE NEEDS, PHYSICALS, SHOTS, ETC.
- ❒ REGIONAL OCCUPATION PROGRAM 925-942-3436
  VOCATIONAL TRAINING – 16 YEARS OLD +
- ❒ OAKLAND CHILDREN'S HOSPITAL 510-428-3000
  MEDICAL NEEDS HEALTH
- ❒ RED CROSS .... (415) 427-8000
  CLASSES, EMERGENCY HOUSING IN DISASTER
- ❒ AIR QUALITY CONTROL 800-334-6367
  REPORTS OF FOUL AIR
- ❒ BROOKSIDE COMMUNITY HEALTH CENTER, SAN PABLO 510-215-9092
- ❒ BROOKSIDE COMMUNITY HEALTH CENTER, RICHMOND 510-215-5001
- ❒ RICHMOND HEALTH CENTER 877-905-4545
- ❒ NORTH RICHMOND CENTER FOR HEALTH 877-905-4545
- ❒ HEALTH ON WHEELS 925-313-6362
- ❒ HOUSE OF HOPE (ST. MARKS CHURCH) 510-234-5886

❒ I WILL BE CONTACTING THE ABOVE CHECKED SERVICES FOR INFORMATION.

❒ I AM NOT INTERESTED IN ANY OF THE ABOVE SERVICES.

______________________________ ______________________
CHILD'S NAME SCHOOL

______________________________ ______________________
SIGNATURE DATE

I HAVE GIVEN A COPY TO STUDENT'S PARENT/GUARDIAN: ______________________
DATE ______________________ Staff Initials

WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT
DECLARATION OF RESIDENCE

I,____, under penalty of perjury, declare as follows:
Parent/Guardian Name

1. My family no longer resides at____
Address City/State Zip

2. On____________________, we changed our legal address to:
Date

____
Address City/State Zip Code

Residing with____
Name of Homeowner

3. My minor child (ren) ____________________________________will reside with me at that address for the ____________________school year.

4. **This declaration is made because of a genuine change of my family's residence, and not for the purpose of changing schools.**

5. **I am aware that stating any false information constitutes perjury, and is a serious violation of the law for which I may be subject to criminal prosecution, including a fine, imprisonment, or both.**

6. **If the information on this form is found to be untrue, the student(s) will be returned to his/her school of residence.**

Executed on the________day of__________________________, 20________ at______________________________, California.
Day Month Year City

______________________________________ ________________________
Signature of Parent Home Phone#

I,____,under penalty of perjury, declare as follows:

1. ____
Mother/Father's Name & Child (ren)

now reside with me at____
Address City/State Zip Code

and have resided with me since____________________
Date

2. **This whole family lives with me on a full-time basis and maintains no other residence. I accept full responsibility (academic, financial, and disciplinary) for the minor child (ren) and his/her parent(s).**

Executed on the ________________day of_______________________, 20_____at______________________________, California
Day Month Year City

__________________________________ Date____________________ Current Home Phone#__________________
Signature of Homeowner

OFFICE USE ONLY

Okay to Enroll________ School____ Verification ____________

Signature of Administrator____ Date ________________________

DECLARATION OF RESIDENCE MUST BE RENEWED ANNUALLY

DISTRITO ESCOLAR UNIFICADO DE WEST CONTRA COSTA
DECLARACIÓN DOMICILIARIA

Yo,____, bajo pena de perjurio, declaro lo siguiente:
Nombre del padre/madre o apoderado

1. Mi familia ya no reside en____
Domicilio Ciudad/Estado Código postal

2. El día__________________________, nos mudamos al siguiente domicilio:
Fecha

____
Domicilio Ciudad/Estado Código postal

Residimos con:____
Nombre del dueño de casa

3. Mi(s) hijo(s) menor(es) de edad ____ vivirán conmigo en esta dirección durante el año escolar __________.

4. **Esta declaración se realiza debido a que verdaderamente se ha cambiado de domicilio, y no con el propósito de cambiarse de escuela.**

5. **Estoy consciente que declarar cualquier información falsa constituye perjurio, y esto es una violación seria de la ley por la cual podría ser enjuiciado y el castigo podría incluir una multa, encarcelamiento, o ambas.**

6. **Si la información de este formulario resultara ser falsa, el estudiante será devuelto a la escuela que le corresponde de acuerdo a su domicilio.**

Ejecutado el __________ día del mes de ______________ de 20______ en_________________, California.
Día Mes Año Ciudad

____________________________________ ____
Firma del padre/madre o apoderado Número de teléfono del domicilio anterior

---

Yo, ____, bajo pena de perjurio, declaro lo siguiente:

1. ____
Nombres del padre/madre y niño(s)

Ahora viven conmigo en ____
Domicilio Ciudad/Estado Código postal

y han residido conmigo desde __________________________
Fecha

2. **Toda esta familia vive conmigo y no tiene otro domicilio. Acepto responsabilidad total (académica, financiera, y disciplinaria) por los niños menores y sus padres**

Ejecutado el día _________ del mes de__________, de 20______en_____________________, California
Día Mes Año Ciudad

__________________________________ Date_________ Número de teléfono de su casa actual ________________________
Firma del dueño de casa

SOLO PARA USO OFICIAL

Okay to Enroll __________ School _______________________________________ Verification _______________

Signature of Administrator____ Date______________________

LA DECLARACIÓN DOMICILIARIA DEBE SER RENOVADA ANUALMENTE

GENERAL RELEASE

For Community Access Cablevision,
Photographs, Videotaping, Interview Comments, and Posting on the Internet

TO: Parents and Guardians
FROM: Principal's Office

Occasionally, the School District and organizations/associations connected with the district would like to use the name, photograph(s), video recording, and/or interview comments of students for educational and promotional purposes, including district-generated news articles and brochures. On occasion the school also receives request from the news media to photograph, film or interview students while covering school events and activities. Such images and comments are used for news purposes only and not for commercial purposes.

As part of each school's parents/community information program, our school or the district may also wish to place students' pictures, schoolwork, and/or names on the district or school's website.

All photography, video recording, student comments, and posting on the Internet are done by legitimate new media personnel. In order to use such material, parental consent is necessary for any student under 18 years of age.

2020-21 SCHOOL YEAR
Please fill out this form and return to your school

Please indicate below if you give permission for your child's name, image, or comments to be used:

For School District publications and educational organizations connected to the district	____YES	____NO
By the news media, including newspapers, radio and television	____YES	____NO
On the district and/or school website	____YES	____NO

I understand that the school and the district have no control over further distribution of a photo or image once it appears in a school or district publication or web site. By signing below, I hereby release the West Contra Costa Unified School district from any damages or injuries claimed by the student or patent related to production or distribution of the photo image.

Student Name: ____

School: ____

Grade: ________PRESCHOOL______________ Teacher: ______________________________

Parent/Guardian Signature: ____

Date: __________________________

WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT
Communications Office (510) 231-1132

RENUNCIA GENERAL

Para el acceso de la comunidad por cablevisión,
Fotos, videos, comentarios de entrevista, y anuncios de la Internet

PARA: Padres y Encargados
DE: Oficina del director

Ocasionalmente, el Distrito Escolar y las organizaciones/asociaciones relacionadas con el Distrito desean usar el nombre, fotos, grabaciones de video y/o comentarios de entrevistas de los alumnos para el propósito educacional y de promoción lo cual incluyen artículos y folletos del Distrito. De vez en cuando, la escuela también recibe peticiones de los medios de comunicación para sacara fotos, filmar ó entrevistar a los alumnos mientras reportan actividades y eventos de la escuela. Tales imagines y comentarios se usan solamente con el propósito de dar las noticias y no con propósitos de lucro.

Como parte del programa de información para los padres y comunidad, su escuela ó el Distrito también desean poner las fotos, tareas escolares, y/ó nombres de los alumnos en la red de comunicación del Distrito ó de la escuela.

Todas las fotografías, grabaciones de videos, comentarios de los alumnos, y los anuncios de la Internet son puestos por personal autorizados de las noticias ó del Distrito escolar. Para poder usar tal información, la autorización del padre es necesaria para cualquier alumno menor de 18 años.

AÑO ESCOLAR 2020-21
Por favor llenar este formulario y devolverlo a la escuela

Por favor indique abajo si usted autoriza usar el nombre, imagen ó comentarios de su hijo/a:

Para publicaciones del Distrito y organizaciones Educacionales relacionadas con el Distrito ____SI ____NO

Por medio de las noticias, periódicos, radio, y televisión ____SI ____NO

En la red de comunicación (Internet) del Distrito ____SI ____NO

Entiendo que la escuela y el Distrito no tienen ningún control sobre la distribución de una foto ó imagen una vez que aparezca en la publicación de la escuela, en el Distrito ó la red de comunicación. Al firmar abajo, declaro que renuncio al derecho a presentar una demanda por daños contra el Distrito Escolar Unificado del Oeste de Contra Costa por parte del alumno ó padre relacionada a la producción ó distribución de la foto ó imagen.

Nombre del alumno: ______________________________

Escuela: ______________________________

Grado: PREESCOLAR Maestro/a: ______________________________

Firma del padre/encargado: ______________________________

Fecha: ______________________________

DISTRITO UNIFICADO DEL OESTE DE CONTRA COSTA
Oficina de Comunicaciones (510) 231-1132

West Contra Costa Unified School District

______________________ **HOME LANGUAGE SURVEY** ______________________ __________

Date | School | Room #

____

Teacher

The California Education Code requires schools to determine the language(s) spoken at home by all students. This information is essential in order for schools to provide meaningful instruction. Please answer questions 1-4 to help us meet this important requirement. In addition, please assist us in the assessment of your child by answering questions A-C. Thank you for your help.

Name of Student:____ ________ ________ ________

Last First Middle Grade Age Sex

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

______________________ ______________________

Signature of Parent or Guardian Home Phone Number

Please write student's date and country of birth. Date of Birth: ________________ Country of Birth: ______________________

month/day/year

(School Office: **If** the country of birth is not the US, send copy of HLS to RAP Center even if English is the only language listed.)

[State of California, Department of Education **OPER - LS 77 R-6/70]**

PLEASE ANSWER THE FOLLOWING QUESTIONS BELOW TO ASSIST US IN THE ASSESSMENT OF YOUR CHILD:

A. Did your son or daughter attend school in another country? ____ ____ If yes, how long ______________________

yes no

B. Has he or she attended school in the United States? ____ ____ If yes, when? ____/____ Where? ____________, ____ ____________

yes no month / year city state school name

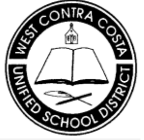
C. Has he or she attended school in WCCUSD schools before? ____ ____ If yes, when? _______ /_______

yes no month year

[EL Services -- WCCUSD -- NS -- Revised 3/11/10]

Attention school office: Retain original in cum folder --- Send copy to ELS, RAP Center, ONLY if it lists a language other than English OR the country of birth is not the U.S. (or both).

WCCUSD STATE PRESCHOOL



CONSENT FOR EMERGENCY MEDICAL TREATMENT

As the parent or authorized representative, I herby give consent to **WCCUSD State Preschool** 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 ____. This care may be given under whatever conditions are necessary to preserve the life, limb, or well being the child named above.

☐ My Child has the following medication allergies: ____

☐ My Child **does not have** any medication allergies

___________________________________ x____________________________________

Date Parent or Authorized Representative Signature

Home Address: ____

Home Phone: ____________________________ Cell Phone: _____________________________________

Work Phone: _____________________________

ASTHMA Questionnaire

☐ My child **does not have** asthma

☐ My child has asthma and needs medication at school

*Please request an "Administration of Medication" for Asthma form in the preschool office.

☐ My Child has asthma, but **does not need** asthma medication at school

Parent signature: ___________________________________ Date: ___________________________

EPI PEN – Food Allergies questionnaire

☐ My child **does not have** any food allergies

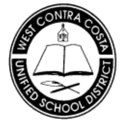
☐ My child has allergies and needs to have the EPI-PEN at school

*Please request a Administration of Prescribed Medication (EPI-PEN) form at the preschool office.

☐ My Child has food allergies, but **does not need** EPI pen at school

Parent signature: ___________________________________ Date: ___________________________

PRE-ESCOLAR ESTATAL DEL DISTRITO WCCUSD



CONSENTIMIENTO PARA TRATAMIENTO MÉDICO EN CASO DE EMERGENCIA

Como padre/madre o representante autorizado, con la presente doy mi consentimiento para que el **Pre-Escolar Estatal del Distrito WCCUSD** obtenga todo tratamiento médico o dental prescrito por un doctor (M.D.) Osteópata (D.O.) o Dentista (D.D.S) debidamente certificado para ____. Este tratamiento médico puede ser proporcionado en cualquier circunstancia necesaria para preservar la vida, miembros del cuerpo, o el bienestar del menor mencionado anteriormente.

☐ Mi hijo/a es alérgico/a a los siguientes medicamentos: ____

☐ MI hijo/a **no tiene** alergias a ningún medicamento.

___________________________________ **x**_____________________________________

Fecha — Firma del padre/madre o representante autorizado

Domicilio: ____

Teléfono de casa: ____________________________ Teléfono celular: _____________________________________

Teléfono de trabajo: __________________________________

Cuestionario sobre el asma

☐ Mi hijo **no tiene asma.**

☐ Mi hijo tiene asma y necesita medicamento en la escuela.

*Por favor pida el formulario de Administración de Medicamento en la oficina pre-escolar.

☐ Mi hijo tiene asma, pero **no necesita** medicamento en la escuela.

Firma del padre: ___________________________________ **Fecha:** ___________________________

EPI PEN – Cuestionario sobre alergias a alimentos

☐ Mi hijo **no sufre** de alergias a ningún tipo alimento.

☐ Mi hijo tiene alergias y necesita una inyección de Epinefrina (EPI-PEN) en la escuela.

*Por favor pida un formulario en la Oficina Pre-escolar para poder administrar la inyección de Epinefrina (EPI-PEN) en la escuela.

☐ Mi hijo tiene alergias a alimentos, pero **no necesita** la inyección de Epinefrina en la escuela.

Firma del padre: ___________________________________ **Fecha:** ___________________________

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School or Agency	2. Site Name	3. Site Phone Number
4. Name of Child or Participant		5. Age or Date of Birth
6. Name of Parent or Guardian		7. Phone Number

8. Description of Child or Participant's Physical or Mental Impairment Affected:

9. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:

10. Indicate Food Texture for Above Child or Participant:

☐ **Regular** ☐ **Chopped** ☐ **Ground** ☐ **Pureed**

11. Foods to be Omitted and Appropriate Substitutions:

Foods To Be Omitted	Suggested Substitutions

12. Adaptive Equipment to be Used:

13. Signature of State Licensed Healthcare Professional*	14. Printed Name	15. Phone Number	16. Date

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or a nurse practitioner.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

INSTRUCTIONS

1. **School or Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served.
3. **Site Phone Number:** Print the phone number of site where meal will be served.
4. **Name of Child or Participant:** Print the name of the child or participant to whom the information pertains.
5. **Age of Child or Participant:** Print the age of the child or participant. For infants, please use date of birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the child or participant's medical statement.
7. **Phone Number:** Print the phone number of parent or guardian.
8. **Description of Child or Participant's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child or participant's diet.
9. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribed by the state healthcare professional.
10. **Indicate Texture: I**f the child or participant does not need any modification, check "Regular".
11. **Foods to be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).
    Suggested Substitutions: List specific foods to include in the diet (e.g., calcium-fortified juice).
12. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child or participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).
13. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.
14. **Printed Name:** Print name of state licensed healthcare professional.
15. **Phone Number:** Phone number of state licensed healthcare professional.
16. **Date:** Date state licensed healthcare professional signed form.

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

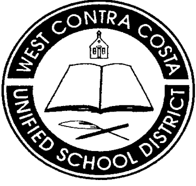
A person with a disability is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

"Has a record of such an impairment" means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.



WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT
Office *of* Teaching, Learning & Leading
Early Learning Programs
State Preschool Program

Parental Income Declaration

Instruction: This form is to be used to secure a written declaration under penalty of perjury form the parent.

Explanation of Need for Declaration:

____
____
____
____
____
____
____
____
____
____
____

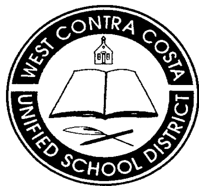
I, ______________________________________, hereby declare under penalty of
(Last Name, First)

perjury and the laws of the State of California that the above information is true and correct with the best of my knowledge.

_______________________________ _______________________
Signature of Parent/Guardian Date

_______________________________ _______________________
Signature of Staff Date

Db201920



DISTRITO ESCOLAR UNIFICADO DE WEST CONTRA COSTA
Oficina *de* Enseñanza, Aprendizaje y Liderazgo
Departamento de Aprendizaje Temprano
Programa Pre-escolar Estatal

Declaración de ingresos de los padres

Instrucción: Esta forma tiene el objeto de ser usada por los padres para hacer una declaración escrita bajo pena de perjurio.

Explicación de la necesidad de hacer esta declaración:

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Yo, ____, con la presente declaro bajo pena
(Apellido, nombre)

de perjurio y bajo las leyes del estado de California que la información proporcionada anteriormente es verdadera y correcta de acuerdo a mi conocimiento.

____ ________________________
Firma del padre o apoderado Fecha

____ ________________________
Firma de un miembro del personal Fecha

WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT
2020-2021 Preschool Student and Parent Information Form

1) STUDENT INFORMATION

School		Date of certification appt.	Enrollment Date		1st time enrollment __ 2nd time enrollment __
Student Last Name	First Name	Middle Name	Age	Grade	Gender : ☐ Male ☐ Female

Student Ethnicity (please check only one)
☐ American Indian ☐ Black/African American ☐ Filipino ☐ Hispanic/Latino ☐ White (Not Hispanic) ☐ Chinese ☐ Japanese ☐ Korean ☐ Laotian
☐ Vietnamese ☐ Asian Indian ☐ Cambodian ☐ Other Asian ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Tahitian ☐ Other Pac Islander

Street Address, City, State, Zip		Home Phone
Date of Birth (mm/dd/yy)	Place of Birth (City/State/Country)	Verification of Birth ☐ Birth Certificate ☐ Other: ______________ Checked by: ___________
Country of Citizenship	Primary Language	Any allergies (food/medicine) or Other medical limitations YES/NO. Please specify:
Number in Family	Is family receiving foods stamps?	Is subject to Asthma attacks?

2) PARENT/GUARDIAN INFORMATION

Please check one: ☐ Mother ☐ Father ☐ Other: ______________________	Last Name	First Name
	Home address:	
	Living with Student? ☐ No ☐ Yes	Language Spoken at Home
Highest Level of Education: ☐ Not High School Grad ☐ College Grad ☐ High School Grad ☐ Grad School ☐ Some College ☐ Decline to State	Home Phone	Cell Phone
	Email	D.O.B
	Parent Ethnicity	Employer
Please check one: ☐ Mother ☐ Father ☐ Other: ______________________	Last Name	First Name
	Home address: ☐ same as above	
	Living with Student? ☐ No ☐ Yes	Language Spoken at Home
Highest Level of Education: ☐ Not High School Grad ☐ College Grad ☐ High School Grad ☐ Grad School ☐ Some College ☐ Decline to State	Home Phone	Cell Phone
	Email	D.O.B
	Parent Ethnicity	Employer

3) CHILDREN IN FAMILY INFORMATION (List all children, including this student, in order of birth)

Name	Birth Date	Current School	Name	Birth Date	Current School

4) LICENSED CHILDREN'S INSTITUTION/FAMILY FOSTER HOME

Facility Name	Contact Person	LCI/FFH#
Facility Address	Facility Phone	Alternate Phone

5) COURT ORDER

Are there any court orders restricting the legal rights of either parent? If you answered YES, please attach a copy of the court order to this registration form.	☐ No ☐ Yes

FOR OFFICE USE ONLY

CPS	IEP	Homeless	Asthma	Allergies	EPI Pen
Adopted	Foster	Food Stamps	15%	Single Parent	

DRISTRITO ESCOLAR UNIFICADO DE WEST CONTRA COSTA
NUEVO FORMULARIO DE MATRICULA 2020-2021

1) DATOS DEL ALUMNO

Escuela		Fecha de inscripción	Fecha de matrícula		Primera vez ___ Re-inscripción __
Apellido del alumno	Nombre	Segundo nombre	Edad	Grado	Sexo : ☐ Masculino ☐ Femenino

Grupo étnico (por favor, marquen sólo uno):
☐ Indio americano ☐ Afro-americano ☐ Filipino ☐ Hispano/Latino ☐ Blanco (no hispano) ☐ Chino ☐ Japonés ☐ Coreano ☐ Laosiano
☐ Vietnamita ☐ Nativo de la India ☐ Camboyano ☐ Otros de Asia ☐ Nativo de Guam ☐ Hawaiano ☐ Samoano ☐ Tahitiano ☐ Otras islas del Pacífico

Dirección: calle, ciudad, estado, código postal,	Número de teléfono del domicilio

Fecha de nacimiento (mes/día/año)	Lugar de nacimiento (ciudad, estado, país)	Certificación del nacimiento: ☐ Acta de nacimiento ☐ Otra: ____________ Verificado por: ___________
Nacionalidad	Primer Idioma	Alergias (Alimentos o medicamentos) o otra limitación medica? SI/ NO Especifique:
Número de miembros en la familia	Recibe la familia estampillas de comida	Es sujeto a ataques de asma?

2) DATOS DE LOS PADRES/APODERADOS

Por favor, marque sólo uno: ☐ Madre ☐ Padre ☐ Otro: ________________________	Apellido	Nombre
	Dirección (si es diferente a la del alumno): calle, ciudad, estado, código postal	
	¿Vive con Ud. el alumno? ☐ Sí ☐ No	Idioma hablado en el hogar
Nivel de estudios: ☐ Secundaria incompleta ☐ Universitarios ☐ Escuela secundaria ☐ Primaria ☐ Preparatoria ☐ No contesta	Teléfono de domicilio	Teléfono celular
	Correo electrónico	Fecha de nacimiento
	Grupo étnico	Trabajo

Por favor, marque sólo uno: ☐ Madre ☐ Padre ☐ Otro: ______________________	Apellido	Nombre
	Dirección (si es diferente a la del alumno): calle, ciudad, estado, código postal	
	¿Vive con Ud. el alumno? ☐ Sí ☐ No	Idioma hablado en el hogar
Nivel de estudios: ☐ Secundaria incompleta ☐ Universitarios ☐ Escuela secundaria ☐ Primaria ☐ Preparatoria ☐ No contesta	Teléfono del domicilio	Teléfono celular
	Correo electrónico	Fecha de nacimiento
	Grupo étnico	Trabajo

3) DATOS DE LOS HIJOS - (Apunte la información de todos los hijos, de mayor a menor, incluyendo a este alumno)

Nombre	Fecha nacimiento	Escuela actual	Nombre	Fecha nacimiento	Escuela actual

4) INSTITUCIÓN AUTHORIZADA DE MENORES/FAMILIA DE CRIANZA

Nombre de la institución	Persona de contacto	Número de LCI/FFH
Dirección del establecimiento	Teléfono del establecimiento	Teléfono alternativo

5) ÓRDENES JUDICIALES

¿Existe alguna orden judicial que limite los derechos legales de cualquiera de los padres? **Si contesta SÍ, adjunte una copia de la orden judicial a este formulario de matrícula**	☐ Sí ☐ No

FOR OFFICE USE ONLY

CPS	IEP	Homeless	Asthma	Allergies	EPI PEN
Adopted	Foster	Food Stamps	15%	Single Parent	

Client List and Record of Wages

La lista de clientes y registro de los salaries

Please provide this and other information that can help our staff verify your eligibility for our services.
Por favor de proporcionar esta y otra información que pueda ayudar verificar y determinar su elegibilidad para nuestro servicio.

Date Fecha	Type of work performed (within 30 days) clase de trabajo realizado (últimos 30 días)	Contact Information Información de contacto	Amount received (please write gross amount) Pago Recivido (escriba cantidad bruta)
			$
Total Cantidad			$

Instruction: This form is to be used to secure a written self-certification under penalty of perjury form the parent.
Instrucción: Esta forma tiene el objeto de ser usada por los padres para hacer una auto-cerificación escrita bajo pena de perjurio.

I, ______________________________________ authorize State Preschool staff to contact my employer(s) to secure and verify information to support my eligibility for services.

Parent Signature: ____ Date: __________________________

Yo, _______________________________autorizo al personal del Pre-Escolar Estatal para que se comunique con mi empleador(es) con el propósito de confirma y verificar la información proporcionada, con el objeto de determinar mi elegibilidad para recibir servicios del programa pre-escolar.

Firma del Padre: ____ Fecha: ________________________

For office use only: Enter date, time, who you spoke to, and outcome of conversation. End all entries with your initial.
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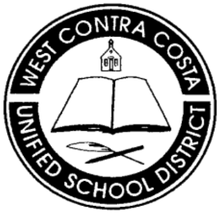

WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT
Office *of* Teaching, Learning & Leading
Early Learning Programs
1108 Bissell Avenue, Room 128
Richmond, CA 94801
Telephone: (510) 307-4585
Email: Preschool@wccusd.net

Sarah Breed
Executive Director

Olanrewaju Ajayi
Coordinator, Early Learning Programs

SELF-EMPLOYMENT DECLARATION FORM

I, ____ parent of ______________________________ certify that
(PLS. PRINT)
I am self-employed and the following information pertaining to my work and income are provided below together with the attached supporting document(s) to verify my eligibility to utilize the services of the West Contra Costa Unified School District State Preschool Program. I understand that Early Learning Department may ask for additional documentation to be able to make a reasonable assessment of my income.

Job Title: ______________________________ Start Date of Self-Employment: ________________________

Number of work hours per day: ____________ Number of work days per week: ________________________

Type of Work Performed: (*Please give a brief explanation about the nature of your job and place of work/ business:*

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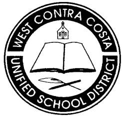
By signing this form, I declare under penalty of perjury under the laws of California that the foregoing is true and correct and of my own personal knowledge and if called upon to testify, I would be competent to testify.

Executed on ____________________ 20 _____ at, ______________________________, California
(DATE)
Parent's Signature:____



WCCUSD State Preschool / 2020-21

Special Needs/Services List

My child ______________________________ has the following special needs/services:

Special Needs/Services (please check all that apply)	**YES** √	**NO** √	**Parent/Guardian Comments**	√ DOC. Attached
CPS under protective services				
CPS at risk				
Homeless				
IEP (Individual Education Plan)				
Foster Child or Adopted				
Restraining Orders				
Court Documents for custody				
Asthma				
Food allergies				
Allergies to medication				
Needs EPI Pen				
Vegetarian / Food restrictions				
Is your child toilet trained?				
Are you a single parent?				
Any other needs/service of which our office and teachers should be aware of, specify:				

Parent/Guardian Signature: _____________________________ **Date:** ___________________

For office use only- Comments or additional instructions: **Staff initials** ______ **Date:** ________

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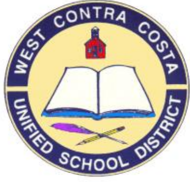

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STATEMENT OF RELEASE

I give permission for West Contra Costa Unified School District State 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 gathered is strictly confidential.

DECLARACION DE AUTORIZACION

Doy permiso para que la West Contra Unified School District State Preschool Program, y su representantes para verificar la información de todos y cada uno de mi empleador para determinar mi elegibilidad de la familia durante el proceso de certificación. Yo entiendo que toda información reunida es estrictamente confidencial.

Child's Name: ____
Nombre del Nino

Parent/Guardian Name*:* ____
Nombre del Padre/Tutor

Parent Signature: ____
Firma del Padre/Tutor

Date: ____
Fecha

Employer's Information/Información del empleador:

Name: ____
Nombre

Address: ____
Dirección

Phone Number: ____
Número de teléfono

Hours of Operation: ____
Horas de Operación

Office use only:____
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