Mono County Office of Education Preschool

THIS FORM MUST BE COMPLETED AND SIGNED

Client Intake Form

Make sure both sides of this form are completed or application can not be processed!

Shaded Areas for Official Use Only

Agency Location:	Intake Staff:	Intake Date:

1 First Name (of Child)	Last Name	Sex	Age	Date of Birth

Street Address	Unit #	City	County	State	Zip Code

Mailing Address (if different than above)	City	County	State	ZIP Code

Telephone Number		Email		Total number of persons living in household including yourself

Family Information

	Name of Household Member	Age	Sex	Date of Birth	Relationship to Child	Ethnicity/ Race (Hispanic/ Not Hisp. Caucasian, Black, Asian, Native, Multi-Race, other)	Education (0-8 Grade, 9-12, HS Graduate, GED, Some Secondary, College Degree)	Other Characteristics (Disabled, Health Insurance, Migrant/ Farm/ Seasonal
2								
3								
4								
5								
6								
7								
8								

Household Information

Mode of Transportation to school:

A. ☐ Car
B. ☐ Walk/Ride Bicycle
C. ☐ Dial-a-ride
D. ☐ Rides from family/friends

Do you rent or own your home?

A. ☐ Rent
B. ☐ Own
☐ Other_____

Family Type *(check one)*

A. Single Parent/Female
B. Single Parent/Male
C. Two Parent Household
D. Single Person
E. Two Adults/No Children
F. Other (Foster Family or Guardianship)
G. Teen Parents (under 20)
H. Single Teen Parent (under 20)

Which Head Start/State Preschool do you live closest to?

A. ☐ Lone Pine
B. ☐ Clarke Street
C. ☐ Little Promises
D. ☐ Mammoth
E. ☐ Lee Vining
F. ☐ Coleville

N/A

Education level for adults

	Adult 1	Adult 2
☐	0-8	0-8
☐	9-12/Non-Graduate	9-12/Non-Graduate
☐	High School Graduate/GED	High School Graduate/GED
☐	12+ Some Post Secondary	12+ Some Post Secondary
☐	2 or 4 year College Graduates	2 or 4 year College Graduates

Household Income Sources

Enter total *gross* monthly income for all persons living in the household:

No Income	$	
TANF	$	
SSI/SSP	$	
Social Security	$	
Pension	$	
General Assistance	$	
Unemployment	$	
Veterans Benefits	$	
Child Support	$	
1 - Employment	$	
2 - Employment	$	
3 - Employment	$	
OTHER	$	
Total Monthly Income	$	
Annual Income	$	
Percentage of Poverty Level		%

Applicants Statement: The information on this application will be used to determine and verify my eligibility for assistance with any MCOE program. I also understand that MCOE does not discriminate in the provision of services on the basis of race, color, national origin, disability, age, or sex. I certify that the information I have given is correct and is not provided with the intent to defraud and I am aware that any deliberate falsification of information will be grounds for immediate dismissal from any MCOE program. I hereby acknowledge that the information relating to the determination of my eligibility requires verification and/or documentation, and that by my signature I authorize all parties, whether agencies or individuals, to release any and all such information.

Applicant's Signature _____ Date _____ Witness' Signature (if signed with an X) _____

Mono County Office of Education Preschool
Client Intake Application

Child's Name: _____

How did you learn about the MCOE Preschool? Radio Newspaper

☐ Sibling attended (Name / DOB): _____ **What year did this sibling attend?** _____

☐ Other _____

1. Does your child have an IFSP or IEP/ or receives services (Speech, worked with GSA)? ☐ Yes ☐ No If yes, please explain.

_____

If your child has an IFSP or an IEP or works with a therapist, we will a need a copy of the IFSP/ IEP/ Referral Letter.

2. Does your child have a chronic condition such as Asthma or require medication? ☐ Yes ☐ No **If yes, please explain:**

_____

If your child has a chronic condition such as Asthma, they will need a signed doctor's explanation/diagnosis before beginning school.

3. Does your child have a special diet or any allergies (food, medication, inhaled, contact, insect)? ☐ Yes ☐ No **If yes, please explain:**

4. Are your child's immunizations Up-To-Date? Yes No **If no is your child on a immunization catch up schedule?

_____

If your child has any allergies or special diet, we will need a signed doctor's explanation/diagnosis before beginning school.

MCOE PS requires that if your child is accepted into our program, your child must have a complete physical and up-to-date immunizations before the first day of school. If you require assistance in finding health insurance please initial here _____

Does this child have health insurance? ☐ None ☐ Medi-Cal ☐ Other:	*Does this child have dental insurance?* ☐ None ☐ Medi-Cal ☐ Other:
Insurance ID#	Insurance ID#
Doctor's Name:	*Dentist's Name:*
City:	*City:*
Date of child's last physical exam:	*Date of child's last dental exam:*

Do you collect any of the following services? If yes to **any** of these, please attach your DOCUMENTATION from these services

Food Stamps	Cash Aid/ CalWORKS/ TANF	Child Support	Unemployment/ Worker's Comp	Survivor Benefits	SSI Disability
			$	$	$

Case #: _____ *Case Worker:* _____ *County:* _____

WIC ☐ *WIC ID#:* _____

Which languages are spoken in your home? Mark all that apply.

English ☐ Spanish ☐ Other: ☐ _____

Which languages does your child speak fluently?

English ☐ Spanish ☐ Other: ☐ _____

In which language do you prefer to be contacted by MCOE preschool (written)?

English ☐ Spanish ☐ Other: ☐ _____

Head of Household **This is the parent who claims head of household on your taxes. This parent will sign the Child Care Data Collection 9600a.**

If this Parent is a single-parent with no live-in partner, you must provide MCOE preschool with proof of single-parenthood, such as court papers, child support papers, or other documented form of proof.

Head of Household: _____ Phone #: _____

Employer: _____ Work Phone #: _____

Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed ☐ Self-Employed ☐ In School ☐ Name of school: _____

If you are unemployed or self-employed, please sign the Survey of Income and Expenses.

How well does Parent 1 **speak English?** ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all

How well does Parent 1 **read English?** ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all

How well does Parent 1 **write English?** ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all

Parent 2: _____ Phone #: _____

Employer: _____ Work Phone #: _____

Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed ☐ Self-Employed ☐ In School ☐ Name of school: _____

If you are unemployed or self-employed, please sign the Survey of Income and Expenses.

How well does Parent 2 **speak English?** ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all

How well does Parent 2 **read English?** ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all

How well does Parent 2 **write English?** ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all

CALIFORNIA DEPARTMENT OF EDUCATION
Form CD 9600A, (Rev. 01/04)

Child Care Data Collection
Privacy Notice and Consent Form

The United States Department of Health and Human Services (HHS) is gathering information about families who receive child care assistance. The information will be reported to the California Department of Education (CDE) and then to HHS. The information will be used for research on the status of child care in the United States and will provide valuable data to persons developing child care programs and policies at the state, local, and national levels.

All the information HHS receives about your family and other families will be summed up and reported to Congress every two years. No person or family will be individually identified in reports made to Congress, the Legislature, other governmental agencies, or the public.

To ensure that children and families receiving child care services are counted only once, HHS and CDE are requesting the Social Security Number of the head of the family unit receiving child care assistance. If you do not wish to give your Social Security Number for this purpose, you may still receive child care assistance. Social Security Numbers will help CDE meet HHS reporting requests and state requirements for program statistics. Authority to ask for your Social Security Number for this purpose is stated in Section 98.71(a)(13) of *Title 45* of the *Code of Federal Regulations*, *Education Code* Section 8261.5, and Section 18070 of *Title 5* of the *California Code of Regulations*. Your decision to provide your Social Security Number is voluntary.

I have been informed of the way my Social Security Number will be used. I understand that if I do not wish to give my number, I can still receive child care assistance.

☐ YES, my Social Security Number may be used: _____-_____-_____

☐ NO, I do not wish to give my Social Security Number for this purpose.

_____ _____
Signature of the Head of Household Date

_____
Type or Print Name

You have the right to access records containing your personal information. For information about this system of records, contact the California Department of Education, Early Education and Support Division, 1430 N Street, Sacramento, CA 95814; telephone (916) 445-1907.

FAMILY SIZE DECLARATION

Name of Child you are requesting services for: _____

☐ **Family Size (parents, step-parents and children under 18 only)**

- Adults and children related by blood, marriage, or adoption in the house where the child above is living
- A child not living with their natural or adoptive parents is a family size of ONE.

Please Check Which One Applies:

_____ I am a single parent living with child/children (Complete the self-certification of Single Parent Status).

_____ We are a father and mother living together with our child/children.

_____ I am a Foster Parent (provide documentation)

_____ I am an adult other than the parent living with the child/children. Relationship: _____

List names and birth dates of all children under 18 years old living in the home: (Include the child listed above)
(You are **required** to provide MCOE with copies of the birth certificates of all children in the family)

Child 1 Full Name: _____ DOB: _____

Child 2 Full Name: _____ DOB: _____

Child 3 Full Name: _____ DOB: _____

Child 4 Full Name: _____ DOB: _____

Child 5 Full Name: _____ DOB: _____

Child 6 Full Name: _____ DOB: _____

I understand that MCOE Preschool has the right to verify information presented here for the purpose of determining eligibility for preschool services.

By signing this document, I am declaring under **penalty of perjury** and the laws of the State of California that the above mentioned is true and correct. I understand that if the information above is found to be false or withholding, the enrollment of my child in the MCOE Preschool is subject to termination.

Parent/Guardian Signature: _____ Date: _____

For office only: I have reviewed the following documents that prove family size and family members.

Documents Reviewed: ☐ Birth Certificates ☐ Court Documents ☐ Other: _____

Staff Signature: _____ Date verified: _____

EMPLOYMENT VERIFICATION FORM (Verificación de Empleo)

INSTRUCTIONS: One form per parent per employment. Please sign/date the release, then MCOE will talk to your employer to have Section II completed. This form must be completed before determining eligibility for MCOE preschool services.

INSTRUCCIONES: Una de las formas por los padres por el empleo. Por favor, firme y fecha de la liberación, después consultar a su patrón para que la Sección II completado. Este formulario debe ser completado antes de determinar la elegibilidad para servicios MCOE preescolar.

Child's Name/*Nombre de nino* _____

I. PARENT RELEASE OF INFORMATION *(Consentimiento de padres para obtener informacion)*

I/ Yo, _____, authorize you, my supervisor, to provide MCOE with any and all information regarding my employment and pay, including exchanging paystubs or payroll history. Yo *autorizo,a mi empleador/ supervisor, para proporcionar MCOE con la siguiente información con respecto a mi empleo.*

Place of employment/ *Lugar de empleo*

_____

Employer Phone Number/*Empleo numero de telefono:* ( ) -

X _____ X _____

Parent Signature/ *Firma de Padre* **Date/** *Fecha*

II. THIS SECTION TO BE FILLED OUT BY EMPLOYER/ SUPERVISOR ONLY:

II. ESTA SECCIÓN SE PARA SER LLENADO POR EL EMPLEADOR / SUPERVISOR SOLO:

MCOE [illegible] / State Preschool may provide child care services for the parent listed above. In order to document eligibility, we are required to obtain the following (and possibly additional) information from the employer:

s is to certify that: _____ started working: _____
(Employee) (Date Started)

s employed with: _____
(Company Name)

located at: _____
(Address. Citv. State. Zip Code)

Paid Rate Hourly $_____/ HR Salaried $_____/ Gross Month

Paid By: ☐ Cash ☐ Checks w/o stu ☐ Paychecks with paystul ☐ Tips ☐ Overtime

Payperiods Are ☐ Weekly ☐ Every 2 Weeks ☐ Twice Month ☐ Monthly

Work Schedule ☐ Actual ☐ Approximate ☐ Seasonal** ☐ Laid off**

**If seasonal or laid off, please provide last day worked:

	Monday	Tuesday	Wednesda	Thursday	Friday	Saturda	Sunday
From:							
To:							

I certify that the above information is true and correct. I understand that MCOE has the right to obtain additional information or confirmation of employment, either written or verbal. This information will not be shared with any other entity except MCOE.

_____ _____ _____

Signature of Employer/ Supervisor **Or** **Print Supervisor's Name/Title** Date

Phone of Supervisor: _____ Extension: _____ FAX: _____

** MCOE may call Supervisor to verbally verify employment status.

MCOE Preschool

Survey of Income and Expenses (ZERO INCOME DECLARATION)

You are being asked to complete this form because your family requested preschool assistance and it was reported that you have no proof of income. The State of California requires all adults (anyone 18 years and over) living in the household to report all sources of income. If an adult claims to have no proof of income, this form must be completed so we can understand how that person is meeting expenses. Please complete the information below:

(One must be filled out for each person in the household 18 and over, if applicable)

PARENT'S NAME:	Phone 1:	
MAILING ADDRESS:	Phone 2:	

Section 1: Do you have sources of income that you need to report?

NO	YES	During the previous month, have you been employed part time? Where? Explain:				
NO	YES	During the previous month, have you been self-employed? Explain:				
NO	YES	During the previous month, did you receive any of the following: (write in how much you received)				
		Worker's Comp/ Unemployment	**CashAid/ TANF/ SSI**	**Child Support**	**Tribal Casino Pay**	**Survivor Benefits**
		$	$	$	$	$

Section 2: Are you spending your savings or borrowing money to cover monthly expenses?

NO	YES	Did you use savings to cover expenses?	How much?
NO	YES	Did you borrow from credit cards?	How much?
NO	YES	Are you borrowing from some other source? What source?	How much?
NO	YES	Did you receive any gift money from someone to help you out?	How much?

Section 3: Please tell us how you paid these monthly expenses during the previous month(s):

EXPENSE	MONTHLY COST	HOW WAS THE EXPENSE PAID?	IF SOMEONE ELSE PAID THIS FOR YOU, PLEASE WRITE THEIR NAME, PHONE #, ADDRESS:
Rent or Mortgage	$		
Utilities (Gas, Electric)	$		
Food	$		
NO YES	Do you receive Food Stamps? If so, how much per month $		

Section 4: If none of the above applies to you, please explain how your monthly expenses were paid:

By signing this form, I affirm that these facts are accurate and true. I give the Service Provider my permission to verify this information. I may be held liable under federal or state law for knowingly making false or fraudulent statements.

Signature/ Date: _____

Office Notes:

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____ . This Child Care Center/School provides a program which extends from _____ : ____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: 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

MCOE Preschool

HEALTH PHYSICAL CHECKLIST

Dear Parent(s) of: _____

Welcome to I MCOE State Preschool! We are glad your family could join us. As part of the pre-enrollment process, we require a complete, up-to-date Health Screening, Physical Assessment and Current Immunizations before attending preschool. Please give this packet to your child's doctor to fill out. Make sure the doctor completes **EVERYTHING ON THIS CHECKLIST** before you leave the clinic, or unfortunately, **we will have to send you back to have it all completed.**

- → HGB/ HCT TEST
- → Lead Test
- → Blood Pressure
- → Height and Weight
- → Vision and Hearing Screen
- → Oral health check (to determine if a dental referral is needed
- → TB test or waiver
- → Physical Exam/ Assessment
- → **Dr needs to note if the child has a diagnosed allergy/ medical condition/ Rx**

Must get a physical prior to the first day of school.

Please return this completed packet (plus additional doctor's notes if applicable) to the preschool or the Administration office at the address to the left. Thank you.

LISTA DE COMPROBACIÓN FÍSICA DE SALUD

Estimados padres de: _____

Bienvenidos a MCOE Preescolar del Estado! Estamos contentos de su familia podrian unirse a nosotros. Como parte del proceso de preinscripción, se requiere una completa y actualizada de la Salud de detección, evaluación física y vacunas al día antes de asistir a preescolar. Por favor, este paquete con el médico de su hijo a llenar. Asegúrese de que el médico completa **TODO EN ESTA LISTA** antes de salir de la clínica, o por desgracia, **tendremos que enviarle de nuevo a tener todo terminado.**

- → Prueba de la sangre HGB/ HCT
- → Prueba de la sangre para el plomo
- → Prueba de presión arterial
- → Altura Y Peso
- → Visión y Oído
- → Una revision de los dientes
- → Prueba de la tuberculosis

Deben tener un físico antes del primer día de escuela.

- → Examen físico/ Evaluación
- → **Se requiere una nota del doctor si el niño se le diagnostica alergia o condicion medica o está tomando un medicamento recetado.**

Por favor devuelva este paquete completo (así como las notas médicas adicionales si es necesario) que el preescolar o la oficina de administración en la dirección hacia la izquierda. Gracias.

MCOE Preschool

CHILD HEALTH RECORD- SCREENINGS, PHYSICAL EXAMINATION, TB ASSESSMENT

PROVIDER PRIOR TO PHYSICAL EXAMINATION/ ASSESSMENT.

Child's Name: _____ Gender: _____ DOB: _____

r: Mono County Office of Education State Preschool Phone: _____

Mailing Address: PO Box 130, Mammoth Lakes Office Ph 760-934-0031 FAX: _____

1. RELEVANT INFORMATION:

2. SCREENING TESTS: Starred items (*) are REQUIRED by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a min. "N" = Normal; "S" = Suspect, or "A" =Atypical/Abnormal.

TEST	DATE	RESULTS
* **Present Age**		Yrs, Mos.
* **Height** (no shoes, nearest 1/8")		
* **Weight** (light clothes, nearest 1/4 lb)		
* **Blood Pressure**		
* **HGB/HCT** (Hemoglobin/Hematocrit)		
* **Lead**		
* **Urinalysis**		
Ova, Parasites		
Other (Indicate)		

TEST	DATE	RESULTS
* **Hearing** (specify type of test)		
Results		
Rescreening		
* **Vision**		
Acuity R/L		
Rescreening		
Strabismus		
Comments:		

Part 2. TO BE COMPLETED BY HEALTH CARE PROVIDER DURING PHYSICAL EXAMINATION/ ASSESSMENT

3. PHYSICAL EXAMINATION/ ASSESSMENT	Normal for Age	Abnormal	Not evaluated
A. General Appearance			
B. Posture, Gait			
C. Speech			
D. Head			
E. Skin			
F. Eyes (external and optic)			
G. Ears (external and tympanic)			
H. Nose, Mouth, Pharynx			
I. Teeth			
J. Heart			
K. Lungs			
L. Abdomen (includes Hernia)			
M. Genitalia			
N. Bones, Joints, Muscles			
O. Neurological/ Social			
(1) Gross Motor			
(2) Fine Motor			
(3) Communication skills			
(4) Cognitive			
(5) Self-Help Skills			
(6) Social Skills			
P. Glands (Lymphatic/ Thyroid)			
Q. Muscular Coordination			
R. OTHER			

General Statement of Child's Physical Status:

Any asthma or allergies?

4. COMMENTS (please print clearly)

SCREENING OF TB RISK FACTORS/ TB WAIVER:

☐ Risk Factors Not Present; TB Skin test not required

☐ Risk Factors PRESENT; Mantoux TB test performed:

_____
Date Test Performed

☐ Neg ☐ Pos

RISK FACTORS FOR TB IN CHILDREN:

→ Have clinical evidence of TB

→ Have abnormalities on chest x-ray suggestive of TB

→ Have contact with or family history of confirmed/suspected TB and/or HIV seropositivity

→ Are in foreign-born families with high prevalence countries (Asia, Africa, Central America, South America)

→ Live in and out of home placements

→ Live with someone who has been incarcerated in the last 5 yrs.

→ Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs or nursing home residents.

CARE PROVIDER'S CLINIC STAMP

Signature and Printed Name

Date

MCOE Preschool Program

Dental Exam/Treatment Record

CHILD'S NAME:_____ DOB:_____

CENTER:_____ DATE:_____

DENTIST: COMPLETE THIS SECTION

*DATE OF DENTAL EXAM:*_____

☐ ORAL HYGIENE: POOR_____ FAIR_____ GOOD_____

☐ GUM DISEASE

☐ VISIBLE CAVITIES/DECAY

☐ VISIBLE FILLINGS/DENTAL WORK PRESENT

☐ SEVERE DENTAL PROBLEMS

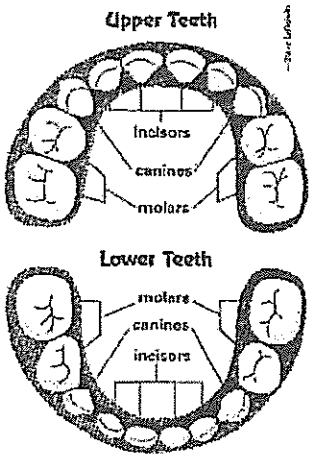
☐ EMERGENCY TREATMENT NEEDED

☐ TEETH ALIGNMENT PROBLEMS (MALOCCLUSION)

☐ OTHER:_____

TOPICAL FLUORIDE APPLIED:

☐ YES ☐ NO



Right Left

SUGGESTED TREATMENT PLAN/COMMENTS
(please mark all that apply)

☐ **Needs treatment**

☐ **Receiving treatment**

Next treatment date:_____

☐ **Treatment complete**
Date treatment was completed:_____

Additional comments:

PRIORITY RATING:

☐ **HIGH PRIORITY**: Urgent/Immediate care is needed (Dental Referral)

☐ **MODERATE PRIORITY**: There are problem areas. Child should see a dentist within 3 months.

☐ **LOW PRIORITY**: No obvious problems. Regular 6-12 month check-ups recommended.

Dentist Signature:_____ **Date:**_____

Dentist License #_____