

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 ongoing parenting classes that focus on the social, emotional and academic aspects of the child's development.

I, the parent of _____

who attends the

4. Parent has 30 days from time of enrollment

Parent acknowledges the rights of California

- 1. To enter, inspect a child care facility with
- 2. To interview children or staff, and to inspect
- 3. To observe the physical condition of child
inappropriate placement and to have a license

Additional information about these topics

I have read, understood, and agree to follow

Parent Signature

I have given a copy of this admission agreement

C3mmuni4y Resources

- ^ LAO FAMILY COMMUNITY DEVELOPMENT
R COUNSELING
- ^ FAMILIAS UNIDAS COUNSELING CENTER
TRANSLATING, JOB REFERRAL, FOOD, COUNSELING
- ^ CC CHILD C

WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT
DECLARATION OF RESIDENCE

I, _____, under penalty of perjury, declare that I am the

Parent/Guardian Name

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

2. On _____, we changed our legal address to:
Date
_____ Address ate City/St Zip Code

Residing with _____
Name of Homeowner

3. My minor child (ren) _____ will reside with me
for the _____ school year.

4. This declaration is made because of a genuine change of my 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 referred to his/her school of residence.

Executed on the _____ day of _____, 20____ at _____ ifornia.
Day Month Year City

Signature of Parent

Home Phone#

I, _____, under penalty of perjury, declare that I am the

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

now reside with me at _____
Address City/State Zip

and have resided with me since _____
Date

2. This whole family lives with me on a full-time basis and maintains no other residence and 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 _____ ifornia
Day Month Year City

Signature of Homeowner

Date _____ Current Home Phone# _____

OFFICE USE ONLY

Okay to Enroll _____ School _____ Verification _____

Signature of Administrator _____ Date _____

DECLARATION OF RESIDENCE MUST BE RENEWED ANNUALLY

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 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 parent related to production or distribution of the photo image.

Student Name: _____

School: _____

Grade: _____ PRESCHOOL _____ Teacher: _____

Parent/Guardian Signature: _____

Date: _____

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 relacionadas con el Distrito desean usar el nombre, fotos, grabaciones de video y/o comentarios de entrevistas de los alumnos para el propósito educativo 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 sacar 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

West Contra Costa Unified School District

Date

HOME LANGUAGE SURVEY

School

Room #

Last Teacher

First

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 Auth <0000>Tj/TT0 1 Tf -0.009 Tw 0.609 0 Tc -0.005 Tw [(M)3.2

* Please request 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: _____

	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 :	
<input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed	
11. Foods to be Omitted and Appropriate Substitutions :	
Foods To Be Omitted	Suggested Substitutions

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: If 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.



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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 from the parent.

Explanation of Need for Declaration :



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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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)
 ' American Indian ' Black/African American ' Filipino ' Hispanic/Latino ' White (Not His 241.06 658.51 T ' Pacific
 ' Tahitian ' Other Pac Islander

Street Address, City, State, Zip _____ + R P H 3 K R Q H

Date of Birth (mm/dd/yy) _____ Place of Birth (City/State/Country) _____ Verification of Birth _____
 ' Birth Certificate Other: _____ Checked by: _____

Country of Citizenship _____

2) PARENT/GUARDIAN INFORMATION

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

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5) COURT ORDER

\$ U H W K H U H D Q \ F R X U W R U G H U V U H V W U L F W L Q J W K H O H J D O U L J K W V R I H L W K H U S D U H Q W "

FOR OFFICE USE ONLY



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1) DATOS DEL ALUMNO

2) DATOS DE LOS PADRES/APODERADOS

3) DATOS DE LOS HIJOS

Client List and Record of Wages

La lista de clientes y registro de salarios

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

Instrucción: Esta forma tiene el objeto de ser usada por los padres para hacer una auto-cerific

WCCUSD State Preschool / 2020-21

Special Needs/Services List

My child _____ has the following special needs/services:

M (please check all that apply)		MN	O	
CPS under protective services				
CPS at risk				
Homeless				



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STATEMENT OF RELEASE

Office use only: _____