

PRESCHOOL ENROLLMENT PROCESS

- Complete the **MANDATORY Interest Form** - available to you at the following link **[ENROLLMENT INTEREST FORM- 2024-2025](#)** or by scanning the QR Code below:



- Pick up an Enrollment Packet** - Can be found on the LJSD Preschool website (www.preschool.ljسد.org) under the "Registration Packet" link and or pick up a printed copy at the District Office located at 11019 Valley Home Ave. Whittier, CA 90603-3042.
- Follow the provided checklist and complete the enrollment packet including the requested documentation prior to moving to the next step.**
- Schedule a Family Intake Appointment with Ms. Christina Lopez, clopez@ljسد.org to review your complete documentation and determine enrollment eligibility.** Your appointment will take place at the Lowell Joint District office located at 11019 Valley Home Ave. Whittier, CA 90603-3042.
- Bring ALL Required Documentation to Your Family Intake Appointment. Incomplete packets will not be accepted and will be rescheduled.**



Follow us on Instagram @LJSDPreschools

***ONLY PARENTS OR LEGAL GUARDIANS CAN FINALIZE THE ENROLLMENT.**

ONLY COMPLETED PACKETS ALONG WITH THE REQUIRED DOCUMENTS WILL BE ACCEPTED.



CALIFORNIA STATE PRESCHOOL PROGRAM FAMILY ELIGIBILITY CRITERIA

Eligibility

Eligibility for enrollment in the preschool program will be based on **documentation and verification**. The parent or guardian is responsible for providing the required documentation, and the Preschool Office Staff is responsible for verifying the required documentation.

Eligibility is based on the documentation and verification of at least one of the following:

- Child Protective Services (CPS) or at risk of abuse, neglect, and/or exploitation;
- Homelessness;
- [Income Eligibility and Family Size](#); or
- Current CalWORKs cash aid recipient.
- Children with Exceptional Needs

Documentation

[Required Documentation](#)

Enrollment Priorities: 10% of CSPP-funded enrollment is set aside for Children with Exceptional Needs.

All families will be ranked based on the following Admission Priorities list, as mandated by the State:

- **First:** The child is the recipient of Child Protective Services (CPS) or is at risk of being neglected, abused, or exploited.
- **Second:** Once the set-aside is filled, children with exceptional needs are from income-eligible families. Prioritize based on income ranking order.
- **Third:** Eligible 4-year-old not enrolled in Transitional Kindergarten. Prioritize children enrolled in CSPP as a 3-year-old, then prioritize dual language learners within each ranking based on the earliest waitlist date. *(4 years old on or before December 1)*
- **Fourth:** Eligible 3-year-old. Prioritize dual language learners within each ranking based on the earliest waitlist date. *(3 years old on or before December 1)*
- **Fifth:** Family income is not more than 15% above the income threshold. Prioritize exceptional needs children, then 4-year-olds, then 3-year-olds. (limited to 10% of funded enrollment)
- **Sixth:** The family resides within approved neighborhood school boundaries. Prioritize Based on income ranking order.

The State of California defines: The child is 4 years old on or before December 1 of the current year of enrollment. 3-year-old: The child is 3 years old on or before December 1 of the current year of enrollment.

An eligibility wait list will be maintained throughout the year to ensure enrollment according to State eligibility guidelines. This waitlist will be utilized to fill vacancies throughout the school year.



REQUIRED DOCUMENTS FOR CSPP FAMILY ENROLLMENT

- **Packet must be completed in blue or black ink**

- Review Attached Current Program Income Eligibility Guidelines - Family Income**
- Current Income - Proof of family income from the last 30 days: Paystubs, CalWORKs notice of action (Cash aid), Child support documentation, self declaration etc.**
 - *Self Employed or Cash Income - Requires additional forms and verification
 - Employment Verification (if needed or requested)
 - Certification of Unemployment (only if unemployed)
- Tuition/Fee Based - Income verification not required.**
- Address Verification - Proof must include a 9 digit zip code**
- Updated Immunization Record of the Child Enrolling for Preschool**
- Current Physical Exam - Signed, Stamped and Dated by a Physician (Lic701 Form)**
- Original Birth Certificate for ALL children living at home and under the age of 18 - Proof of family size**
- Picture ID of Parents/Legal Guardians**
- Complete ALL Attached State & District Consent Forms, Signed, and Dated**
- Individualized Educational Plan (IEP) - A copy of the IEP must be submitted if applicable.**
- Emergency Contacts and Phone Numbers - We must have at least three (3) emergency contacts and phone numbers. Persons must be 18 years or older with proof of identification and will be notified for pick up or emergency if guardian is not available. (Lic700 Form)**
- Schedule a Family Intake Appointment with Ms. Christina Lopez, clopez@ljsd.org to review your CSPP documentation and complete enrollment.**
ONLY COMPLETED PACKETS ALONG WITH THE REQUIRED DOCUMENTS WILL BE ACCEPTED.

**Lowell Joint Preschool Program reserves the right to ask for additional information to verify eligibility.*

***ONLY PARENTS OR LEGAL GUARDIANS CAN FINALIZE THE ENROLLMENT.**

STATE FUNDED PRESCHOOL PROGRAM INCOME ELIGIBILITY GUIDELINES
2024/2025

The following Schedule of Income Ceilings must be used for determining income eligibility for families initially certified or recertified on or after July 1, 2023. The schedule must also be used for determining maximum monthly income for 15 percent above the income eligibility threshold.

Please see [Management Bulletin 23-06](#) for more information effective through July 1, 2023.

Family	Family Yearly Income Ceiling (100% of SMI)	Family Monthly Income Ceiling (100% of SMI)	Maximum Monthly Income for 15% above Income Eligibility Threshold
1-2	\$86,514	\$7,209	\$8,291
3	\$97,843	\$8,154	\$9,377
4	\$113,292	\$9,441	\$10,857
5	\$131,419	\$10,952	\$12,594
6	\$149,546	\$12,462	\$14,331
7	\$152,944	\$12,745	\$14,657
8	\$156,343	\$13,029	\$14,983
9	\$159,742	\$13,312	\$15,309
10	\$163,141	\$13,595	\$15,634
11	\$166,539	\$13,878	\$15,960
12	\$169,938	\$14,162	\$16,286

Effective July 1, 2023, contractors must use the revised Income Ranking Table at <https://www.cde.ca.gov/sp/cd/ci/documents/incomerankingtable202324.xlsx> when determining enrollment priorities for families. The revised Income Ranking Table is not provided for the purposes of determining eligibility for CSPP.

If you have any questions regarding the information in this MB, please contact your assigned Early Education Program Quality Implementation (PQI) Regional Consultant via the CDE Consultant Regional Assignments or by phone at 916-322-6233.



TUITION-BASED PRESCHOOL PROGRAM FEES

2024/2025

Tuition-Based Preschool Program: 2024/2025	
Registration fee: \$ 150.00 per child	
Part Day/3 hour (M-F) Program Tuition Rates:	Monthly Rate
8:00 AM - 11:00 AM - Jordan Preschool	\$ 600.00
12:15 PM - 3:15 PM - Jordan Preschool	\$ 600.00
Full Day (M-F) Program Tuition Rates:	Monthly Rate
8:00 AM - 3:15 PM - Olita Preschool	\$ 900.00
8:00 AM - 3:15 PM - Macy Preschool	\$ 900.00

- 1st month's tuition is due on the first of each month, beginning August 1, 2024.
- A **30-day written notice** is required to cancel enrollment. Tuition **will not** be refunded or credited if proper written notice is not received 30 days prior to start.
- Fees are based on a 10 month enrollment. Prorated amounts **will not** be granted for non school days and fall/winter/spring breaks.
- Credit is not given for any day in which your child is absent from preschool.
- Tuition is due the **1st of each month** for the current month.
- **My School Bucks** account is required for registration and monthly payments. Video instructions available at link [My School Bucks Instructional Video](#) or step by step instructions are in the registration packet.
- Cash or cashiers check accepted.
- Personal check by request only. NSF fees and penalties may apply.



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LOWELL JOINT SCHOOL DISTRICT
CHILD DEVELOPMENT SERVICES
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**FEE BASED CONTRACT
2024/2025**

- Registration Fee is \$150 per child.
- 1st month's tuition is due on the first of each month, beginning **Aug 1, 2024** .
- A **30-day written notice** is required to cancel enrollment. Tuition **will not** be refunded or credited if proper written notice is not received 30 days prior to start.
- Fees are based on a 10 month enrollment. Prorated amounts **will not** be granted for non school days and fall/winter/spring breaks.
- Credit is not given for any day in which your child is absent from preschool.
- Tuition is due the **1st of each month** for the current month.
- **My School Bucks** account is required for registration and monthly payments. Video instructions available at link [My School Bucks Instructional Video](#) or step by step instructions are in the registration packet.
- Cash or cashiers check accepted.
- Personal check by request only. NSF fees and penalties may apply.

Part Day Preschool Program-**Monthly Fee \$600.00**

Full Day Preschool Program-**Monthly Fee: \$900.00**

I have read and understand the information stated above. I also understand non-payment will result in termination of enrollment in the preschool program.

Child's Name

Date of Birth

Parent/Guardian Signature

School Site

Print Name

Date

District Office Staff Only:

Department Coordinator Signature

Date Received

EMPLOYMENT VERIFICATION

Parent / Guardian First and Last Name (Printed) Child's Name

Business Name Company Contact Name Company Phone Number

Company Street Address City Zip Code

- LJSD and its representatives have my permission to contact my employer to verify my employment and income information to determine my family eligibility during the enrollment or certification process. I understand all information gathered is strictly confidential.
- My employer has refused or failed to provide a requested employment information. (Attach paystub and self-complete employer information) **(Option for part day CSPP ONLY)**

Parent / Guardian Name (Print) Parent / Guardian Signature Date

EMPLOYER DECLARATION - COMPLETED BY EMPLOYER

This is to certify that _____ is employed by _____

Form & Frequency Paid (Please check all that apply)

- Check Cash Weekly Every other week Commission Monthly
- Twice per month Monthly bonus Annual bonus Overtime Other: _____

The above mentioned person works from:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	From:	From:	From:	From:	From:	From:
To:	To:	To:	To:	To:	To:	To:

Days per week: Do vary **Daily Hours:** Do vary

Start date of employment: _____ Today's Date: _____

Employer Name (Print): _____ Employers Signature _____

Employer Phone Number: _____ Employer Email Address: _____

<p>FOR STAFF USE ONLY: STAFF INITIALS _____ STAFF NAME: _____</p> <p>VERIFIED THE ABOVE WITH EMPLOYER ON: _____ SPOKE WITH (NAME / TITLE) : _____</p>



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SELF-CERTIFICATION OF NON-EMPLOYMENT INCOME

Parent / Legal Guardian's Name: _____

Child's Name: _____

When no other documentation is available, this form is used to document income. Please record undocumented employment income, non-employment income and periods of zero income.

NON-EMPLOYMENT INCOME: Self-certification of my non-employment is as follows:

Type of income: _____
 Who is the income for: _____
 Amount of income: \$ _____
 How often received: _____

ZERO INCOME: Self-certification of my zero income was received as follows:

Date zero income began: _____
 Date zero income ended: _____

Why zero income was received and/or how the family was supported:

I swear under penalty of perjury, to the best of my knowledge, that the above information is true and correct. I understand that any fraudulent, incomplete, deceitful, or misleading information provided to Lowell Joint Union School District's California State Preschool Program regarding status of income, family size, employment, unemployment, seeking employment, initial or ongoing eligibility for services may be grounds for termination of services.

 Parent/Legal Guardian Name (Print)

 Parent / Legal Guardian Signature

 Date

For office use only: The agency representative signature below serves as an attestation that the parent/guardian reported income and if applicable employment is reasonable and/or consistent with community practice.

Agency Representative Name: _____ Signature: _____ Date: _____



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Residency Verification

2024/2025

Homeowner Renter Co-Residency Other: _____

Parent(s) / Guardian(s) Name: _____

Last Name

First Name

Middle Name

Address: _____

Number

Street

Apt. #

City

Zip Code

Please provide the following documents **under your name** to establish residency.

One (1) of the following

Or

Two (2) of the following

Correspondence from government Agency. (E.g. Social Security, DMV, Cal Works Letter, Cal Fresh Letter, Medical Letter, EDD, WIC Letter, etc.)

Deed to Home

Mortgage Escrow Paperwork

Rental Lease Agreement

Property Tax Bill or Tax Return

Drivers' License / California Identification Card

Current Automobile Insurance Policy

Current Payroll Stub

Current Electric Bill

Current Gas Bill

Current Water Bill

Current Waste Management Bill

Current Cable Bill

If you cannot provide proof of residency **under your name**, please have the primary resident/owner of the shared home provide the documents listed above in addition to completing the section below.

Co-Resident

I, _____ declare that I am the primary resident/Owner of
Full Name of Primary Resident /Owner

the address listed above and that the person(s) claiming the address reside(s) with me at least five (5) days per week. I further declare that all of the information provided in this Residency Verification Affidavit, including information provided by the parents/ guardian(s), is true and correct. I will submit the required documents to verify my residency. I agree to notify Lowell Joint School District if there are any changes in the status of the residency of the person(s) claiming the address or myself.

I swear (or certify) under penalty of perjury that the foregoing is true and correct.

Signature of Primary Resident / Owner

Date



ETHNICITY, RACE & LANGUAGE SURVEY

The Federal Government requires a **two-part question** to collect race and ethnicity data on all students. Such data is summarized, AND TOTAL FIGURES ARE USED FOR SCHOOL AND DISTRICT REPORTING PURPOSES. The California Department of Education requests your input on home language. **COMPLETE ALL SECTIONS.**

ETHNICITY Mark the ethnicity with which the student most closely identifies.

Hispanic / Latino (A person of Cuban, Mexican, Puerto Rican, South or Central America or other Spanish culture or origin, regardless of race)

Not Hispanic / Latino

RACE Please check ONE OR MORE of the selections indicating which race(s) the student most closely identifies.

American Indian or Alaskan Native

(Person having origins in any of the original peoples of North and South America, including Central America)

Asian

- Chinese
- Japanese
- Korean
- Vietnamese
- Asian Indian
- Laotian
- Cambodian
- Filipino
- Hmong
- Other Asian

Native Hawaiian or other Pacific Islander

- Hawaiian
- Guamanian
- Samoan
- Tahitian
- Other Pacific Islander

Black or African American

White

(Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East)

LANGUAGE: Complete the following 4 questions

- 1) Which language(s) does your child hear at home? *This includes the language(s) spoken by parents, grandparents, siblings, extended family, or others living within or visiting the home _____
- 2) Which language(s) does your child hear in their neighborhood / community? *For example, with friends and neighbors, at church or after school programs or activities. This is to demonstrate language exposure, not to measure language proficiency. _____
- 3) Which language(s) does your child understand? _____
- 4) Which language(s) does your child speak? _____

Name of Student: _____

Parent / Guardian Signature: _____ Date: _____



LJSD HEALTH HISTORY

School Year: _____

Name: _____ Male Female Date of Birth: _____
School: _____ Grade: _____ Teacher: _____
Physician: _____ Physician Phone Number: _____
Health Insurance Plan: Private: _____ Medi-Cal: _____ None: _____

PLEASE CHECK ALL THAT APPLY

PAST MEDICAL HISTORY None
Premature Birth (35 weeks or earlier) Diabetes Seizures / Epilepsy
Heart Defect/Heart Disease Hearing Problems ADD/ADHD
Frequent Headaches Wears Glasses Frequent Ear Infections
Other: _____

ALLERGIES None Allergic to Bee/Wasp Stings
Food Allergies: Peanuts Milk Other: _____
Environmental Allergies: Latex Hay fever Household Animals Dust Grass Pollen Mold

Type of Allergic Reaction:
 Local Reaction - Pain, itching, minimal swelling and redness at site of contact
 Systemic Reaction - Difficulty breathing, flushing of skin, rash, faintness
Requires Epinephrine Pen at School? Yes No
 Medication to treat Allergies (list Medicines): _____

ASTHMA NONE
Triggered by: Sickness Seasonal Exercise Other
Requires Medication: Daily As Needed Only With Exercise
Medications Required At School: Inhaler Nebulizer Other: _____

ADDITIONAL MEDICAL INFORMATION NONE
 Surgeries/Hospitalization: _____
 Illness: _____
 Physical Handicaps: _____
 Other: _____

CURRENT DAILY MEDICATIONS NONE WILL MEDICATIONS BE GIVEN AT SCHOOL?
1. _____ YES NO
2. _____ YES NO
3. _____ YES NO
4. _____ YES NO

Please remember that ALL medications, including inhalers or over the counter substances have 3 requirements in order to be given at school. 1). Parent permission AND 2). Physician order AND 3). Matching pharmacy label on bottle. Children are NOT permitted to carry ANY medication at school without permission from the doctor AND school nurse.

Parent Signature: _____ Date: _____

CHILDS HEALTH AND DEVELOPMENT SCREENING

Medical Health

1. Do you have medical insurance for your child?

If yes: Medi-Cal Covered CA Kaiser Other:

2. Does your child have any chronic health issues such as asthma, diabetes, epilepsy?

Please explain:

Yes No

3. Does your child have any allergies?

Yes No If yes, please indicate here: _____

4. Does your child take any medication?

Yes No If yes, please indicate here: _____

Dental Health

1. Do you have dental insurance for your child?

Yes No

If yes: Medi-Cal Covered CA Kaiser Other:

2. Has your child been seen by a dentist for a dental check-up within the last year? Yes No

Dental Clinic: _____ Date of last visit: _____

3. Does your child brush his/her teeth two or more times a day? Yes No

Hearing and Vision

1. Does your preschooler hear and understand most of what is said at home? Yes No

2. Does your preschooler speak so that he or she can be understood most of the time? Yes No

3. Does your preschooler currently wear corrective lenses / glasses? Yes No

Growth and Nutrition

1. Does your child eat five or more servings of fruits and vegetables each day? Yes No

2. Does your child watch TV more than two hours a day? Yes No

3. Is your child physically active for a total of 60 minutes or more each day? Yes No

Developmental

1. Is your child's growth and development within schedule? Yes No

2. Does your preschooler use 3 or 4-word sentences? Yes No

3. Have you observed your child having difficulty doing things expected for his/her age? Yes No

If yes, please explain: _____

4. Has your child ever received services such as speech, physical, occupational therapy? Yes No

If yes, please explain: _____



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PARENT CONSENT FOR HEALTH SCREENING

Lowell School District is providing evaluations through the California State Preschool Program. The screenings will assist the School Readiness Nurses in identifying children who may need referrals for medical intervention. Your written consent is required for the nurses to conduct any of these screenings with your child. The School Readiness Nurses are also available to assist you if you are in need of health insurance and/or other community resource services. This screening is not intended to replace any medical evaluation. It has a limited scope and is not designed to uncover all problems. Lowell School District is not responsible for treatment or therapy for conditions uncovered by this screening.

The following screenings and services will be provided throughout the school year:
(circle yes or no)

- Hearing Yes No
- Vision Yes No

Health information may be shared with appropriate school personnel Yes No

Health information concerning my child may be released to the appropriate agencies assisting in the care of my child and the school my child will be attending after preschool. Yes No

With my signature below, I give my consent for screenings listed above. I understand that I will be provided with a written report.

Student's Name: _____ DOB: _____

Parent / Guardian Signature: _____ Date: _____

For further information about mental health screenings, please contact the school readiness nurse.

The School Readiness Nurse Program is funded by a grant provided by The Children & Families Commission of Orange County.



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AUTHORIZATION OF THE ADMINISTRATION OF SUNSCREEN

2024/2025

Name of Child _____

Date of Birth _____

In order for LJSD Preschool Staff to apply sunscreen to your child, you will need to provide the sunscreen you prefer, as well as this completed form, to your child's Teacher. **PLEASE, CLEARLY MARK YOUR CHILD'S NAME IN PERMANENT MARKER ON THE BOTTLE/TUBE.**

We will keep the sunscreen on site and will assist your child in applying sunscreen. Please replenish sunscreen as needed.

I hereby give permission for LJSD Preschool Staff to assist my child in applying sunscreen as needed.

Parent/Guardian Signature

School Site

Print Name

Date

LOWELL JOINT SCHOOL DISTRICT

PLEASE PRINT

STUDENT INFORMATION FORM

COMPLETE ALL SECTIONS

Pupil's Name: _____			Entering Grade: _____	Current Date: _____
Last	First	Middle	()	
			Primary Phone Number	
Street Address		City	Zip	County
Parent/Guardian E-mail Address				
Birth Date: _____			<input type="checkbox"/> Male	<input type="checkbox"/> Female
Month		Day	Year	
School Last Attended: _____			Last Day of Attendance: _____	
Name				
School Address: _____				
Street Address		City	State	Phone Number
			()	()
				Fax Number

Ethnic Identity: Is this student Hispanic or Latino? (*Select only one*) No, not Hispanic or Latino Yes, Hispanic or Latino (Required by CA Gov Code Sec. 8310.5)

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.**

<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Tahitian
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Filipino	<input type="checkbox"/> Hmong	<input type="checkbox"/> Laotian	<input type="checkbox"/> Samoan	<input type="checkbox"/> White

FAMILY INFORMATION

Who has legal custody of this pupil? Father _____ Mother _____ Foster _____ ID # _____ Other _____

Please specify ()

Father/Guardian	Address (If different from above)	City	<input type="checkbox"/> Cell or <input type="checkbox"/> Home Phone #
Father's Employer	Address	City	<input type="checkbox"/> Cell or <input type="checkbox"/> Home Phone #
Mother/Guardian	Address (If different from above)	City	<input type="checkbox"/> Cell or <input type="checkbox"/> Home Phone #
Mother's Employer	Address	City	<input type="checkbox"/> Cell or <input type="checkbox"/> Home Phone #

Other Adult Living In the Home: _____

Name Relationship

Other Children Living in the Home:

Name	Relationship	Date of Birth	Name	Relationship	Date of Birth

Parent Education Level (Please circle highest grade level completed) Required by the Public Schools Accountability Act, Education Code Section 60630:

Father: <input type="checkbox"/> High School Graduate	<input type="checkbox"/> Not a High School Graduate	<input type="checkbox"/> Some College	<input type="checkbox"/> College Graduate	Mother: <input type="checkbox"/> High School Graduate	<input type="checkbox"/> Not a High School Graduate	<input type="checkbox"/> Some College	<input type="checkbox"/> College Graduate
<input type="checkbox"/> Graduate School	<input type="checkbox"/> Decline to State	<input type="checkbox"/> Graduate School	<input type="checkbox"/> Decline to State	<input type="checkbox"/> Graduate School	<input type="checkbox"/> Decline to State	<input type="checkbox"/> Graduate School	<input type="checkbox"/> Decline to State

Was your child enrolled in a special program? Yes _____ No _____

Type of services and/or program (please check): Special Education (IEP) _____ ELD _____ Gifted and Talented _____

Speech/Language Therapy _____ 504 Plan _____ Other type of program not listed: _____

Has your child ever attended school in Lowell Joint School District? Yes _____ No _____

If yes, name of school: _____ Grade(s) attended _____

Did your child attend pre-school? Yes No If yes, name of pre-school: _____

I certify that all information provided in this application and any supporting document(s) is true and correct.

_____ Date _____

Parent/Guardian Signature **Date**

FOR OFFICE USE ONLY

Grid: _____ Teacher: _____ Enrollment Date: _____ Address Verified: _____

Permanent Records Requested: _____ Permanent Records Received: _____ Birth Date Verified By: _____

Immunization Status: _____

DISTRITO ESCOLAR LOWELL JOINT

FAVOR USAR LETRA DE MOLDE

FORMA DE INFORMACION DEL ESTUDIANTE

LLENE CADA SECCIÓN

Nombre del Estudiante: _____ Entrando Grado: _____ Actual Fecha: _____
 Apellido _____ Nombre _____ 2do Nombre _____ () _____
 Número de Teléfono Primario _____

Domicilio _____ Ciudad _____ Zona Postal _____ Condado _____ Correo Electrónico del Padre/Tutor _____

Fecha Nacimiento: _____ Mes _____ Día _____ Año _____ Masculino Femenino

Ultima Escuela que Asistió: _____ Ultimo Día de Asistencia: _____
 Nombre _____

Domicilio de la Escuela: _____ () _____ () _____
 Domicilio _____ Ciudad _____ Estado _____ Número de Teléfono _____ Número de Fax _____

Identificación Étnica: ¿Es el estudiante hispano o latino? (Escoja sólo uno) No, ni hispano o latino Sí, hispano o latino (Requerido código gobierno Calif., secc. 8310.5)
 No importando su selección en la parte anterior, **favor de continuar contestando lo siguiente marcando uno o mas espacios para indicar lo que considera que es su raza.**

Nativo Americano/Nativo Alaska Camboiano Guameiano Japonés Asiático - Otro Tahitiano
 Indio Asiático Chino Hawaiano Coreano Otra Isla del Pacifico Vietnamita
 Negro o Afroamericano Filipino Hmong Laosiano Samoano Blanco

INFORMACIÓN FAMILIAR

¿Quien tiene custodia legal de este alumno? Padre _____ Madre _____ Padre de Cria (Foster) _____ # Identificación _____ Otro _____
 Sea Especifico () _____

Padre/Tutor _____ Domicilio (Si es diferente al de arriba) _____ Ciudad _____ Número de Casa o Celular _____
 () _____

Empleador del Padre _____ Domicilio _____ Ciudad _____ Número de Casa o Celular _____
 () _____

Madre/Tutora _____ Domicilio (Si es diferente al de arriba) _____ Ciudad _____ Número de Casa o Celular _____
 () _____

Empleador de la Madre _____ Domicilio _____ Ciudad _____ Número de Casa o Celular _____
 () _____

Otros Adultos Viviendo en el Hogar: _____ Nombre _____ Relación _____

Otros Niños Viviendo en el Hogar:

Nombre	Relación	Fecha de Nacimiento	Nombre	Relación	Fecha de Nacimiento

Nivel Educativo del Padre (Favor de marcar el año escolar mas alto terminado) Requerido por el Acto de Contabilidad de Escuelas Públicas, Código Educacional Sección 60630:

Padre: Graduado No Graduado Algo de Graduado de Graduado de Graduado de
 Preparatoria de Preparatoria Universidad Universidad Preparatoria de Preparatoria Universidad Universidad
 Posgraduado Rehusa Declarar Posgraduado Rehusa Declarar

¿Estuvo su hijo/a inscrito en un programa especial? Sí _____ No _____

Tipo de servicios y/o programa (favor marque): Educación Especial (IEP) _____ ELD (Aprendiz de Inglés) _____ Habilidad Especial/Talento _____

Terapia Habla/Language _____ Plan 504 _____ Otro tipo de programa no mencionado: _____

¿Ha asistido su hijo/a a alguna escuela dentro del Distrito Escolar Lowell Joint? Sí _____ No _____
 Si sí, nombre de la escuela: _____ Grado(s) asistido _____

¿Asistió su hijo/a al preescolar? Sí No Si sí, nombre de la escuela preescolar: _____

Certifico que tanto la informacion proporcionada en esta forma como los documentos que se acompañan, son corretos y verdaderos.

Firma del Padre o Tutor _____ Fecha _____

FOR OFFICE USE ONLY Grid: _____ Teacher: _____ Enrollment Date: _____
 Address Verified: _____ Permanent Records Requested: _____ Permanent Records Received: _____
 Birth Date Verified By: _____ Immunization Status: _____



Lowell Joint School District
Early Learning Services
 11019 Valley Home Ave. Whittier, CA 90603-3042
 Phone: (562) 943-0211 Fax: (562) 947-7874



PHOTO/PUBLICITY PERMISSION

2024/2025

The Lowell Joint School District (LJSD) is known for its outstanding and talented students. From time to time, the district would like to publicize their achievements for the purpose of positive public relations. Because these events and interviews are almost always needed at the last moment, we are requesting parental permission for the 2024/2025 school year, rather than on a case-by-case basis.

Please note that when the media is on campus, we cannot prohibit them from interviewing students or including them in photographs or news stories. This permission form is for the district to issue publicity.

- I **give** my permission for my child to be featured in district-issued publicity, including district publications, the district website and announcements.
- I **do not give** my permission for my child to be featured in district-issued publicity, including district publications, the district website and announcements. However, I **do give** permission for my child to be included in the yearbook, honor roll and other school-issued publicity.

If you do not give permission for your child to be photographed, please make sure that your child is aware of this decision.

 Parent/Guardian Signature

 Student Name (please print)

 School Site

 Date

On Campus Field Trip Parent Permission Form

2024/2025

Dear Parent or Guardian,

The preschool programs that are part of the Lowell-Joint School District are licensed preschool programs. There are specific areas and buildings on campus that are licensed. Because of our unique position on the elementary school campuses, we have access to many opportunities outside of the licensed facilities.

In order for our children to participate in these programs and go into the unlicensed facilities on our campus, we are asking for parent permission to go to facilities on the campus that are not licensed. For the purpose of this, we are calling these "**off-site**" field trips. This means that your child will be **off of the licensed site**. When children go "**off-site**", they will remain in the care of their regular preschool teachers. While away from the licensed facility on campus, children will remain in the appropriate safety ratios. This paperwork will accompany the staff that is supervising your child. Some of the "**off-site**" field trips may include school pictures, assemblies, preschool activities, rewards for school fundraisers, preschool health and developmental screenings, kindergarten readiness screenings, or other whole school activities. Areas of the school campus that may be visited include the cafeteria, the multi-purpose room, the main school office, shared outdoor spaces such as the field, the school library, or other school facilities.

Child's Name

My child has permission to leave the licensed facilities of the Jordan/Olita/Macy Elementary School campus.

I understand that my child will be out of the licensed preschool facilities. I understand that my child will remain in the appropriate teacher to student ratio while out of the licensed facilities on the school campus. My emergency contact information in my child's preschool file will accompany the teacher for the duration of the activity.

Parent/Guardian Signature

School Site

Print Name

Date



**Lowell Joint
School District**

A Tradition of Excellence Since 1906

**Lowell Joint School District
Early Learning Services**
11019 Valley Home Ave. Whittier, CA 90603-3042
Phone: (562) 943-0211 Fax: (562) 947-7874



LOWELL JOINT SCHOOL DISTRICT
CHILD DEVELOPMENT SERVICES
"Come Grow With Us"

SURVEY FOR FAMILY INTERESTS AND NEEDS

Student Name: _____

INFORMATION ABOUT	YES	NO	NOTES
Healthy food and nutrition classes			
Low cost clinics			
Places that provide emergency food			
Classes on Positive Parenting Strategies			
How to support your child to be successful in school			
School Readiness			
Domestic Violence			
Social Services. WIC. etc.			
Mental Health			
Dual Language Program in the Lowell Joint School District			
Community engagement programs for children			
Do you need information on any other topic?			

Are you interested in participating in the P.A.C. (Parent Advisory Committee) called LJSD Parent Cafe?	YES	NO
--	-----	----

Please circle the position of your interest:			
President	Vice President	Secretary	Parent/Guardian Participant

Parent / Guardian Signature: _____ Date: _____

**Lowell Joint School District
Preschool Admission Agreement**

As the parent or legal guardian of the below named student, my initial and signature signifies that I understand, agree to, and/or acknowledge the following:

A. I have reviewed a copy of the Parent Handbook and will comply with the policies set forth (Parent Handbook is available on the LJSD website.) _____

B. I have reviewed, signed, and understand the On-Campus Field Trip Permission Slip. _____

C. LJSD staff and volunteers are not allowed to babysit or transport children at any time outside of the LJSD Preschool Program. _____

D. I am not to leave my child at the LJSD preschool classroom unless a LJSD teacher is there to receive and supervise my child. _____

E. Should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse but to contact the police. (Please do not put staff in a position where they have to make this judgment call.) _____

F. LJSD is mandated by state law to report any child abuse or neglect to the appropriate authorities for investigation. _____

G. LJSD may terminate my child's enrollment for any of the following reasons. _____

- Emergency contact names and phone numbers are incorrect,
- Parent/Guardian is continually late picking up the child after the LJSD session ends.
- Non/Late/NSF payment of tuition fees.
- Failure to adhere to the sign in/out procedures.
- Failure to notify LJSD school site that the child will be absent.
- Child leaving the LJSD school site without authorized written permission.
- Behavior that is continually disruptive or dangerous to others and/or self.
- Behavior that is destructive to property and/or refusal to replace said property.
- Any single incident that is deemed by the Program Coordinator to be dangerous, harmful, or disruptive.
- Harassment, violent behavior or treatment of such behaviors against a staff person or other members by parent/guardian or persons associated with the child (family member, family friend, etc.)

H. Program participation requires a LJSD in good standing. Non-payment of fees will result in my child not being allowed to participate in the program and could result in legal referral with additional costs to myself. I further understand that there is an administrative processing fee for any payment returned by my bank or credit account. Refunds and/or credits are not given for any day in which a child does not attend the program including school closures or seasonal breaks. _____

I. LJSD and the staff employed by the LJSD will not become involved in any custodial disputes between parent/guardian. If LJSD documents are requested, the court must request them. The staff's responsibility is to provide a safe environment for children. _____

J. I understand that I am required to give a 30-day written notice when terminating from the JLSD Preschool Program. **If 30-day written notice is not given, I will not receive a refund or credit.** _____

K. Children and staff have the option to wear a mask during the preschool program. _____

L. 48 hour fever free clearance will be required prior to children returning to program participation. _____

M. **All children must be toilet independent and able to use the restroom unassisted.** This includes independently removing clothing, wiping independently, refastening clothing and hand washing. Please be reasonably sure that your child has demonstrated that they are physically ready. In extreme cases, parents will be contacted to assist their child. _____

N. **The Community Care Licensing Division of California Department of Social Services (Section 101200)** has the authority to interview children or staff to inspect and audit child or facility records without prior consent. The licensee shall make provisions for private interviews with any child(ren) or any staff member and for the examination of all records relating to the operation of the facility. The licensing agency has the opportunity to observe the physical condition of the child(ren), including conditions that could indicate abuse, neglect, or inappropriate placement. _____

Child's Name: _____

DOB: _____

Parent/Guardian Signature: _____

Date: _____

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

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

Lowell Joint School District - Macy Preschool TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____. THIS CARE MAY BE GIVEN UNDER
NAME

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

()

IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ()
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
BIRTHDATE					
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ()
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ()
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					
PERSON RESPONSIBLE FOR CHILD	LAST	MIDDLE	FIRST	HOME TELEPHONE ()	BUSINESS TELEPHONE ()

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

CALL EMERGENCY HOSPITAL OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY
 (CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN
 AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE
---	------

**TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY
 CHILD CARE HOMES LICENSEE**

DATE OF ADMISSION	LAST DATE OF ENROLLMENT
-------------------	-------------------------

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)

Lowell Joint School District - Macy Preschool _____ . 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: _____

Address: _____

Telephone: _____

Date of Physical Exam: _____

Date This Form Completed: _____

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.

Parents' Guide to Immunizations

Required for Pre-Kindergarten (Child Care)



Parents must show their child's Immunization Record as proof of immunizations (shots) before starting pre-kindergarten (child care) and at each age checkpoint after entry:

Age at Entry/checkpoint	Required Doses
2-3 Months	1 Polio 1 DTaP 1 Hep B 1 Hib
4-5 Months	2 Polio 2 DTaP 2 Hep B 2 Hib
6-14 Months	2 Polio 3 DTaP 2 Hep B 2 Hib
15-17 Months	3 Polio 3 DTaP 2 Hep B 1 Hib* (on or after 1st birthday) 1 Varicella 1 MMR (on or after 1st birthday)
18 Months-5 Years	3 Polio 4 DTaP 3 Hep B 1 Hib* (on or after 1st birthday) 1 Varicella 1 MMR (on or after 1st birthday)

* One Hib dose must be given on or after the 1st birthday regardless of previous doses.
Required only for children younger than 5 years old.

DTaP = diphtheria toxoid, tetanus toxoid,
and acellular pertussis vaccine
Hep B = hepatitis B vaccine
Varicella = chickenpox vaccine

Hib = Haemophilus influenzae, type B vaccine
MMR = measles, mumps, and rubella vaccine

Guía Para Padres Sobre Las Vacunas

Requeridas Para Pre-Kínder (Guardería)



Los padres deben proporcionar el Comprobante de Inmunización del niño/a como prueba de vacunación antes de empezar el pre-kínder (guardería) y durante cada punto de control de edad después de ingresar.

Edad al ingresar/ punto de control	Dosis requeridas
2–3 meses	1 Polio 1 DTaP 1 Hep B 1 Hib
4–5 meses	2 Polio 2 DTaP 2 Hep B 2 Hib
6–14 meses	2 Polio 3 DTaP 2 Hep B 2 Hib
15–17 meses	3 Polio 3 DTaP 2 Hep B 1 Hib* (al cumplir el 1 ^{er} año de edad o después) 1 Varicela 1 MMR (al cumplir el 1 ^{er} año de edad o después)
18 meses–5 años	3 Polio 4 DTaP 3 Hep B 1 Hib* (al cumplir el 1 ^{er} año de edad o después) 1 Varicela 1 MMR (al cumplir el 1 ^{er} año de edad o después)

*Una dosis contra el Hib se debe aplicar al cumplir el 1^{er} año de edad o después, independientemente de las dosis anteriores.

Se requiere sólo para niños menores de 5 años de edad.

DTaP= vacuna contra la difteria, el tétanos y la tos ferina acelular

Hep B= vacuna contra la hepatitis B

Hib= vacuna contra haemophilus influenzae tipo B

MMR= vacuna contra el sarampión, las paperas y la rubéola.

CHILD’S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD’S NAME	SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
IS / HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/ MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY *(*For infants and preschool-age children only)*

WALKED AT* _____ MONTHS	BEGAN TALKING AT* _____ MONTHS	TOILET TRAINING STARTED AT* _____ MONTHS
----------------------------	-----------------------------------	---

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Asthma <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Hay Fever		<input type="checkbox"/> Diabetes, <input type="checkbox"/> Epilepsy <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Mumps		<input type="checkbox"/> Poliomyelitis <input type="checkbox"/> Ten-Day Measles (Rubeola) <input type="checkbox"/> Three-Day Measles (Rubella)	

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
--	------------------------	---

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*	
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*	
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST		
	LUNCH		
	DINNER		
WHAT ARE USUAL EATING HOURS?	BREAKFAST		
	LUNCH		
	DINNER		
ANY FOOD DISLIKES?		ANY EATING PROBLEMS?	
IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	
PARENT / AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S HEALTH			

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?*	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

PARENT/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT/AUTHORIZED REPRESENTATIVE SIGNATURE	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: Orange County Child Care Regional Office

Licensing Office Address: 750 The City Drive South, Suite #250, Orange, CA 92868

Licensing Office Telephone #: (714) 703-2800 8:00am - 5:00pm

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.

Lowell Joint School Dist. - Olita or Macy Preschool
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

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:

Community Care Licensing Division

NAME

Orange County Child Care Regional Office

ADDRESS

750 The City Drive South, Suite #250

CITY

Orange

ZIP CODE

92868

AREA CODE/TELEPHONE NUMBER

(714) 703-2800

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)

Lowell Joint School District - Macy Preschool

(PRINT THE ADDRESS OF THE FACILITY)

2301 Russell Street, La Habra, CA 90631

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)



**Lowell Joint
School District**

A Tradition of Excellence Since 1906

"Home of Scholars and Champions"



LOWELL JOINT SCHOOL DISTRICT
CHILD DEVELOPMENT SERVICES
"Come Grow With Us"

Preschool Uses Learning Genie!

Dear Preschool Families,

The Preschool Program uses the **Learning Genie's Digital Sign In/Out Attendance Reporting and Daily Health Card Screening.**

*The Daily Health Card feature will be implemented if recommended by CDC's health guidelines.

Parents or guardians **must** submit a digital Daily Health Card **BEFORE** entering the classroom. The Daily Health Card may be completed from home on your mobile device or other electronic device using the Learning Genie application. If you are unable to complete the Daily Health Card from home, an iPad will be available outside of the classroom for your use.

Upon arrival at the classroom, staff will review the Digital Daily Health Card information and check your healthy child in.

The Learning Genie application is designed to protect your children, keep you informed, and adhere to health screening and social distancing regulations. The Daily Health Card screening will build trust, help provide peace of mind, and instill confidence within our school community. Learning Genie improves communications between teachers and student's families. Through this application, we will be able to update you on your child's learning progress, send photos and reports, and provide ways for you to continue enhancing your child's early learning at home. Preschool staff will only share photos of your child in group photos with your child's class. **Your child will be excluded from shared class photos if you have a signed non-consent form in your child's file.**

Please become part of this experience! All you need to do is download the free mobile application on your iPhone or Android device. It is also available for your home computers and iPads. The application is labeled "**Learning Genie For Parents**" **Preschool Staff will provide you with an access code to log in into your account.**

**Preschool Personnel
Lowell Joint School District
www.preschool.ljzd.org**





Learning Genie: The Basics

Sign in/Sign out Remotely. This is the main tool to be used by our parents for the child's drop off and pick up process and the reporting of absences.

Get updates on your child's day. Receive real-time updates and photos on our devices. Summary reports are sent to your email regularly.

Continue the learning at home. Learning activities and video books shared through the application allow families to expand on the child's learning from home.

Two-way messaging. Teachers and families can chat instantly, with translations of multiple languages, so no one gets left out.

Safe for Everyone. All of your child's information is kept secure and confidential on the Learning Genie platform. Learning Genie's software is protected through secure-socket layering via Amazon Web Services, is compliant with HIPAA and FERPA regulations, and has obtained the iKeepSafe California Student Privacy Badge.

*** Daily Health Card Screening.**

Answer the screening questions as accurately as possible. Your information will be handled confidentially. Additionally, please have **alternate plans for emergencies** in the event your child is not permitted to stay for class. Together we are working to protect our children, school environment, and community to be as safe as possible.

*This feature will be implemented if recommended by CDC's health guidelines.

Frequently Asked Questions by Families

How do I sign up for a Learning Genie Parent Account?

- You will receive a code from the Preschool Staff
- Download the Learning Genie Parent Application on your device
- Sign in with your parent code.

How long is my child's data saved in the system?

- Your data will be retained in the system up to three years after children leave preschool.
- The data will be removed if preschool chooses to permanently delete children's information.

What if I have more than one child using Learning Genie in separate classrooms?

- Learning Genie assigns each child a separate parent code. Each parent application can have multiple children attached.

What are the best practices for using Learning Genie for social media?

- Learning Genie recommends that families approach public social media with caution.
- Posting photos of other children in any public space compromises those children's privacy.
- If you decide to share a picture, please share those of your child only.



LOWELL JOINT SCHOOL DISTRICT
CHILD DEVELOPMENT SERVICES
"Come Grow With Us"

Parent/Guardian Handbook Acknowledgement

I, the undersigned, acknowledge that I have received a copy of the Parent/Guardian Handbook for the Lowell Joint School District Preschools and child development programs. While I understand that the Parent/Guardian Handbook is neither a contract nor a legal document, I recognize that it is my responsibility to read and understand the policies, provisions, and procedures contained in the Parent/Guardian Handbook.

In addition, I understand that the contents of the Parent/Guardian Handbook are subject to change. I acknowledge that the Parent/Guardian Handbook will be revised in accordance with the rules or regulations of state, federal, and accrediting entities, best practices for child care service providers, or at the discretion of the Lowell Joint School District. I recognize that any such revisions will supersede, modify, or eliminate the current contents of the Parent Handbook.

Moreover, I recognize that it is my responsibility to contact the Child Development Services Coordinator for any questions I might have about the contents of the Parent Handbook now and in the future.

Parent/Guardian Name (Print)

Student's Name (Print)

Parent/Guardian Signature

Date