**Winzler Children's Center**
Eureka City Schools Preschool Programs
719 Creighton Street, Eureka CA 95501
Phone: (707) 441-2498 FAX: (707) 441-3308
NAEYC Accredited Program

Your application will be considered complete when all of the required paperwork is received, and then you will be notified when your child has been placed on our eligibility list/waiting list.

Please indicate your interest. Check all that apply.

- ❑ **½ Day State Preschool** 3 hours to 3.75 hours daily
- ❑ **Extended Day Preschool** 6.5 hours or more
- ❑ **Special Day Class - Room 4**

Required from **all** applicants:

- ❑ Completed enrollment packet including:
  - Housing Survey
  - Home Language Survey
  - Student and Family Information Sheet
  - Child's Preadmission Health History--Parent's Report
  - Media Refusal Form
- ❑ Physician's Report including all immunizations/proof of appointment
- ❑ Copy of student Birth Certificate/proof of application, payment, and postage for an official copy
- ❑ Copy of Insurance or Medi-Cal Card

Other required information/documentation if applicable:

Does your child have an IEP? Circle one: Yes No

- ❑ If yes, a copy of IEP

Are you a single parent? Circle one: Yes No

If yes, is there a legal custody agreement? Circle One: Yes No

- ❑ If yes, a copy of court papers/proof of custodial parent

Required from those **seeking state-subsidized half day preschool:**

**Verification of all income:**

- ❑ Check stubs for the **full prior month**
- ❑ Current Passport to Services
- ❑ Child support verification
- ❑ Social Security or SSI payment notification
- ❑ Self-employed: profit & loss statement for the past 3 months
- ❑ Documentation of any additional income source

Verification of Family Size:

- ❑ Copy of Birth Certificate of all additional children in the household/proof of application, payment, and postage for official copy or Passport to Services
- ❑ If applicable, statement of providing primary child support and caregiving

Required from those **seeking subsidized part day or full day extended day preschool**:

Verification of need:

- ❑ Work Verification Permission form
- ❑ Self-employed documentation including; a copy of Business License, workspace lease, or rental agreement
- ❑ Training/education verification
- ❑ Parental incapacity/Medical statement from a physician
- ❑ Family at risk/CPS statement from qualified professionals
- ❑ Seeking housing statement and referral from a legal agency
- ❑ Seeking employment statement

# Eureka City Schools Preschool Enrollment Application

Child and Family Information

| **Date application completed:** / / |
|---|

**Child's Information:**

| **Childs Name** (Last Name, First Name, Middle Initial) | **Date of Birth** | **Gender** (circle one) |
|---|---|---|
| | | Male Female Non-Binary |

| **Hispanic or Latino?** | **Child's Race** (check one) |
|---|---|
| (circle one)<br>Yes No | 1. American Indian or Alaskan Native___ 2. Asian ___ 3.Black or African American___<br>4. Caucasion___ 5. Native Hawaiian or other Pacific Islander___ |

**Child's Address** (Please include City and Zip Code)

| | | |
|---|---|---|
| | | |
| Street Address | City | Zip Code |

**Parent/Guardian Information:**

**Primary Parent** (circle one):

| | |
|---|---|
| Mother Father<br>Other(explain) | |

| **Parent's Name** (Last Name, First Name): | **Place of Employment or School** |
|---|---|
| | |

| **Home Phone** | **Cell Phone** | **Work Phone** |
|---|---|---|
| | | |

**Secondary Parent** (circle one) :

| | |
|---|---|
| Mother Father<br>Other(explain) | |

| **Parent's Name** (Last Name, First Name): | **Place of Employment or School** |
|---|---|
| | |

| **Home Phone** | **Cell Phone** | **Work Phone** |
|---|---|---|
| | | |

**Emergency Contacts** (Over 18 years old)

List contacts other than the primary or secondary parents; list in order of preference for contact after parents.

| **Name/Relationship to Child**: | **Home Phone**: | **Work Phone**: |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

# Child and Family Information (Cont.)

## Family and Household Members

| Relationship | Name | Birthdate | Gender | Living in Home? |
|---|---|---|---|---|
| Primary Parent | | | M F N-B | Yes No |
| Secondary Parent | | | M F N-B | Yes No |
| List ALL children living in your home including children enrolling in the program | | | M F N-B | Yes No |
| | | | M F N-B | Yes No |
| | | | M F N-B | Yes No |
| | | | M F N-B | Yes No |
| | | | M F N-B | Yes No |
| | | | M F N-B | Yes No |

Funding: ☐ Full Cost ☐ Subsidized by the State of California - See below

**Subsidized Eligibility** Complete this section if you checked **Subsidize** in the upper box

| Primary Parent Name: | | | | | |
|---|---|---|---|---|---|
| Type of Eligibility: (check one)<br>☐ Working ☐ Seeking Employment ☐ Training ☐ At Risk ☐ Seeking Permanent Housing ☐ Parent Incapacitation | | | | | |
| Name of Employer or Trainer: | | | | | |
| **Schedule**<br>Do Not Include Travel Time | Monday | Tuesday | Wednesday | Thursday | Friday |
| | | | | | |

| Secondary Parent Name: | | | | | |
|---|---|---|---|---|---|
| Type of Eligibility: (check one)<br>☐ Working ☐ Seeking Employment ☐ Training ☐ At Risk ☐ Seeking Permanent Housing ☐ Parent Incapacitation | | | | | |
| Name of Employer or Trainer: | | | | | |
| **Schedule**<br>Do Not Include Travel Time | Monday | Tuesday | Wednesday | Thursday | Friday |
| | | | | | |

# Employment Verification

Winzler Children's Center
719 Creighton St
Eureka CA 95501
(707) 441-2498 FAX (707) 441-3308

Child's Name: _____

I, _____, authorize the release of employment verification information to Winzler Children's Center and Eureka City Schools in order to determine eligibility for child care subsidies provided by the Department of Education, Child Development Division. I declare under penalty of perjury that the information provided below is true and correct to the best of my knowledge. I will notify the agency immediately if there is any change in my income, employment status, or work schedule.

☐ I request that Winzler Children's Center does NOT contact my employer.

_____ _____
Parent Signature Date

| Employer Name | Employer Telephone Number |
|---|---|
| Employer Address (Include City and State) | Employer Fax Number |

**To be completed by employer.** Employer, please complete all lines on the form below and return to Winzler Children's Center by Fax or Mail. This information is needed immediately and must be returned directly to the agency. Please note that your employee has given permission to release this information.

| Name and Title of Person Completing Form | Signature | Date |
|---|---|---|
| | | |

| First day of employment | Date this shift started | When will schedule change? |
|---|---|---|
| | | |

Assigned time each day this person typically works i.e. 8:00 AM to 1:00 PM

| Monday | Tuesday | Wednesday | Thursday |
|---|---|---|---|
| | | | |
| Friday | Saturday | Sunday | *Please write any special notes on the back of this form and sign. |
| | | | |

| | |
|---|---|
| Does employee receive lunch break: ☐ Yes ☐ No<br>If "Yes," how long? _____ minutes<br>☐ Paid ☐ Unpaid | Does employee work all of these hours every week?<br>☐ Yes ☐ No |
| Does the schedule change? ☐ Yes ☐ No<br>If "Yes," how often does the schedule change? ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly | Avg. Hrs. Per Week: |

| | | | | |
|---|---|---|---|---|
| **Earnings:** | **Hourly** rate (before taxes) | Commissions?<br>☐ Yes ☐ No | Does employee receive sick leave or holiday pay?<br>☐ Yes ☐ No | |
| **Payroll Periods:** | ☐ Daily | ☐ Weekly | ☐ Every Two Weeks | ☐ Twice a Month | ☐ Once a Month |

**Note To Employers: This information will be included in a file that is subject to periodic review by State auditors.**

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| **Earnings:** **Hourly** rate (before taxes) | Commissions?<br>☐ Yes ☐ No | Does employee receive sick leave or holiday pay?<br>☐ Yes ☐ No |
|---|---|---|

**Payroll Periods:** ☐ Daily ☐ Weekly ☐ Every Two Weeks ☐ Twice a Month ☐ Once a Month

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# STUDENT AND FAMILY INFORMATION SHEET

***Winzler Children's Center***

Today's Date: _____

Student First Name: _____ Last Name: _____

Name you call your child? (Given or nickname): _____

Parent(s) or Legal Guardian: _____ email: _____

**CUSTODIAL INFORMATION:** Do both parents live in the home? ☐ Yes ☐ No

Who provides primary care and support for the child? _____ Relationship: _____

Who has physical custody of the child? _____

If only one parent or adult has custody of the child, may the non-custodial parent(s) pick up the child from the Center? ☐ Yes ☐ No

**If no**, please supply the Center with court or other documentation to support this arrangement.

Documentation on file?

☐ Yes ☐ No

**INTERESTS, ACCOMPLISHMENTS, PLAYTIME AND SCHOOL:** Please list 3 of your child's interests:

_____

_____

Please list 3 things you are proud of, that your child does well:

_____

_____

Does your child have the opportunity to play with other children at home? ☐ Yes ☐ No If yes, who?

_____

Has your child attended home daycare, preschool, or daycare centers? If yes, please list:

Where: _____ When: _____

Please complete the sentence: I hope that at preschool this year my child will _____

_____

**REST TIME:** If your child is with us during rest time (after lunch), would you prefer your child to:

☐ Nap (for sleepers) OR ☐ Rest Quietly (for non-sleepers)

**ADDITIONAL HEALTH INFORMATION:** Has your child ever been stung by a bee or wasp? ☐ Yes ☐ No

If Yes, what was the reaction? _____

If no, has anyone else in your family had a severe reaction? ☐ Yes ☐ No

If yes, what was the reaction? _____

**PERSONALITY AND BEHAVIOR:** Give a brief description of your child's personality:

_____

_____

Does your child have any chores or responsibilities at home? ☐ Yes ☐ No If Yes, please list:

_____

How do you make sure that your child follows the rules at home?

_____

What do you do if your child refuses to follow the rules?

_____

Check if your child exhibits any of these behaviors:

☐ Sulk or pout ☐ Have tantrums ☐ Suck fingers

☐ Hit when angry ☐ Bite ☐ Suck clothing or other items

What do you do when your child does any of these things?

_____

_____

_____

**FAMILY BACKGROUND:** Which languages are spoken in the home?

_____

Does your family have any special cultural or religious practices of which we need to be aware? ☐ Yes ☐ No

If yes, please explain: _____

**READING AT HOME:** Please describe the occasions you read with your child:

_____

**SCHOOL SUPPORT:** Would you be willing to share a talent, interest or cultural activity with our students? If yes, list. (Examples include: leading students in a cooking or creative art project, teaching students a song or reading a story in another language, playing a musical instrument.) _____

Our Parent Advisory Committee meets 4 times each year. Would you be interested in serving on our Parent Advisory Committee?

☐ Yes ☐ No

Would you be interested in supporting the school by periodically preparing learning materials at home (such as cutting, stapling, etc.)

☐ Yes ☐ No

**REFERRAL:** How did you find out about Winzler?

# 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* | BEGAN TALKING AT* | TOILET TRAINING STARTED AT* |
|---|---|---|
| _____ MONTHS | _____ MONTHS | _____ MONTHS |

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

| | DATES | | DATES | | DATES |
|---|---|---|---|---|---|
| ☐ Chicken Pox | | ☐ Diabetes | | ☐ Poliomyelitis | |
| ☐ Asthma | | ☐ Epilepsy | | ☐ Ten-Day Measles (Rubeola) | |
| ☐ Rheumatic Fever | | ☐ Whooping Cough | | ☐ Three-Day Measles (Rubella) | |
| ☐ Hay Fever | | ☐ Mumps | | | |

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

| DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ 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?* ☐ YES ☐ NO | IF YES, AT WHAT STAGE:* | ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO | WHAT IS USUAL TIME?* |
| 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? ☐ YES ☐ NO | IF YES, NAME OF DOCTOR: | DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO | IF YES, WHAT KIND AND ANY SIDE EFFECTS: |
| DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO | IF YES, WHAT KIND: | DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO | IF YES, WHAT KIND: |

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 |
|---|---|
| | |

# 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

**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.

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Consult with your local health department's TB control program on any aspects of TB prevention and treatment.