Lennox School District

SCHOOL READINESS CENTER

2019/2020

La Casita	La Escuelita	Jefferson Readiness	Moffett Readiness
4944 Lennox Blvd.	4125 E. 105th St	10203 Firmona Ave.	11050 Larch Ave.
Lennox, Ca. 90304	Lennox, CA. 90304	Lennox, CA. 90304	Lennox, CA.90304
310) 680-8990	(310) 680-6290	(310) 680-3500	(310) 680-6292
Blanca Marroquin	**Esther Bryant**	**Blanca Marroquin**	**Esther Bryant**
Tuesday/Thursday	**Monday/Wednesday**	**Monday/Wednesday**	**Tuesday/Thursday**
7:30 AM - 4:00 PM	7:30 AM - 4:00 PM	7:30 AM - 4:00 PM	7:30 AM - 4:00 PM
12:00 – 1:00 LUNCH	12:00 – 1:00 LUNCH	12:00 – 1:00 LUNCH	12:00 – 1:00 LUNCH

Please return this application with the following documents:

- ☐ **1. BIRTH CERTIFICATE:**
  - Birth Certificates
  - Adoption documents
  - Records of Foster Care
  - Court orders regarding child custody
  - Other reliable documentation
- ☐ **2. CHILD'S IMMUNIZATION RECORD:**
  - If the child is 3 years at Tuberculosis Skin Test is required. If the doctor determines thae child is not at risk, a TB skin test is not necessary but it must be noted on the physician's report.
- ☐ **3. ADDRESS VERIFICATION (2 PROOFS – WITHIN 30 DAYS):**
  - The following documents are acceptable: driver's license, gas bill, checkbook, electricity bill, telephone bill, etc…
- ☐ **4. PHYSICIAN'S REPORT: WITH DOCTOR'S SIGNATURE, STAMP AND DATE**

  The physical must include:
  - Hearing and vision examination
  - Documentation of any other concerns, IE: seizures, asthma, allergies, etc…
  - Developmental delays or speech concerns
  - If you child ahs a currect ISFP or IEP provide a copy
- ☐ **TB CLEARANCE FOR PARENT OR ADULT ATTENDING PROGRAM W/CHILD**
  - Tuberculosis Skin test within 1 year or X-RAY or blood work within 4 years
- ☐ **PROVIDE AN IDENTIFICATION CARD FOR PARENT OR GUARDIAN**

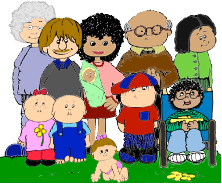
MORE INFORMATION REGARDING TB VACCINATION:

T.H.E. Clinic, Inc. located at ***10223 Firmona Avenue in the city of Lennox***. Please call to make an appointment **(310) 695-4017. The cost for TB test is $25**

Curtis Tucker Clinic located at ***123 Manchester Blvd*** **(310) 419-5325.**
No appointment necessary for a **FREE TB Test.**
Walk-in hours: M/W/F 8:00am-4:00pm, Tuesdays 10:00am-5:30pm
Thursdays 12:30pm- 4:00pm.

The lack of compliance with these requirements can delay your child's enrollment.

We will only Accept complete Applications.



Lennox School District Readiness Center

La Casita La Escuelita Jefferson Moffett

(Por favor, marque la escuela que está solicitando)

REGISTRATION APPLICATION

Name of parent/Guardian filling this form: ______________________________

Relationship to child: ______________________ Date: ______________

Address: ____

Phone Number: ______________ Cell Phone Number: ______________

Student's Information

First Name	Middle Name	Last Name
Date of Birth	**Age**	**Birthplace**

Parent's Information

Name of mother/Guardian	Cell Phone Number
Name of father/Guardian	**Cell Phone Number**

PARENT'S INFO	Date of Birth	Birthplace	Education (Not a High School Graduate, High School Graduate, Some College, College Graduate)	Ethnicity	# of years in this country
Mother					
Father					

Other Adult Attending Program Information

Name	Relationship to Child	Address	Telephone

Are you employed? no yes Employer: ______________________

Is your spouse employed? no yes Employer: ______________________

Do you have **dental** insurance for your child? no yes, what type? ______________

Do you have **health** insurance for your child? no yes, what type? ______________

What services do you already have or currently use?

Lennox Park Lennox Library St. Margaret's Center

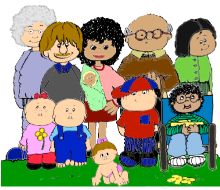
Lennox Schools WIC Healthy Start

Is your child allergic to any food or substances? no yes, explain: ______________

____

Is your child physically limited in any way? no yes explain: ______________

____



Lennox School District
10319 Firmona Avenue, Lennox CA 90304
School Readiness Center

HEALTH AND SOCIAL SERVICE NEEDS

Date: ____________________

Child's Name:____ School: ________________________________

Parent(s) Name(s): ____

Address: ____

Telephone Number: ______________________________ Altenative Number: ________________________________

Nuumber is household: _____________ Language other than English in home: ________________________

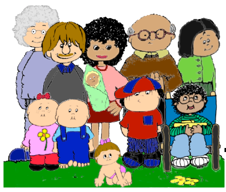
1. Do you need information of referrals in any of the following areas: (check all that apply)

	Food Assistance		Family Counseling
	Housing		Parenting Education/Information
	Home Buyer's Assistance		GED Information
	Dental Referrals		ESL/Citizenship Information
	Employment Training		Employment
	After School Program		Legal Assistance
	Clothing		Tutoring
	Nutrition		Recreational Activities
	Crisis Prevention		Anti-Substance Abuse Training
	Gang/Crime Prevention		Counseling
	Naturalization		Emergency Housing
	Tranportation		Medical/Insurance
	Health/Immunization		Other:

2. Do you have any concerns about your child in any of the following areas: (check all that apply)

	Hearing		Learning/Cognitive Development
	Vision		Social Development
	Speech/Language		Physical Development
	Behavior/Emotional Development		Other: (specify)
	Has your child attended other programs (i.e.; West Regional Center, Carousel? If so, which program?		

________________________________ ________________
Parent's/Guardian's Signature Date



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HOME LANGUAGE SURVEY

Name of Student:
____

Surname / Family Name) (First Given Name) (Second Given Name)

Age of Student: ______ Grade Level: _______ Teacher Name: _________________________________

Directions to Parents and Guardians:

The California *Education Code* contains legal requirements which direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with these requirements. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered. If an error is made completing this home language survey, you may request correction before your student's English proficiency is assessed.

1. Which language did your child learn when he/she first began to talk? ______________________________
2. Which language does your child most frequently speak at home? ______________________________
3. Which language do you (the parents or guardians) most frequently use when speaking with your child? ______________________________
4. Which language is most often spoken by adults in the home? ______________________________

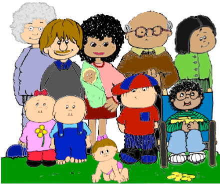
   (parents, guardians, grandparents, or any other adults)

Please sign and date this form in the spaces provided below, then return this form to your child's teacher. Thank you for your cooperation.

____ ________________________

Signature of Parent or Guardian Date

Form HLS, Revised December 2016
California Department of Education



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STUDENT EMERGENCY FORM

First Name	Middle Name	Last Name
Dathe of Birth	**Gender**	**Phone NUmber**
	Male Female	
Address	**City**	**Zip Code**

Name of Mother/Guardian	Work Address	Cell Phone Number	Work Phone Number
Name of Father/Guardian	**Work Address**	**Cell Phone Number**	**Work Phone Number**

Does your child have an Individual Educational Program (IEP) or (IFSP)? ☐ Si ☐ No

Child lives with:

☐ Both Parents ☐ Natural Father Only ☐ Natural Mother only
☐ Natural Father-Stepmother ☐ Natural Mother-Stepfather ☐ Foster Parents
☐ Legal Guardians ☐ Ward of the Court ☐ Relative
☐ Joint Custody ☐ Other (please specify ____________________

If needed, are there legal documents on file at the Lennox School Readiness Center (Restraining Order, Joint Custody, etc. ☐ Si ☐ No

If student lives with one parent, may student be released to natural parent?
☐Si ☐No Parent's Name________________________________

Names of Brothers/Sisters	Date of Birth	School of Attendance	Grade

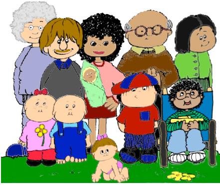
List the individuals to whom we may call or who we can release your child to incase of an emergency. The person will need to show photo identigfication when picking up your child.

Name	Address	Phone Number	Relationship
		( )	
		( )	
		( )	
		( )	

Doctos Name	Address	Medical Plan and #	Telephone Number

☐ **Incase of an emergency I authorize school personnel to obtain emergency medical treatment for my child and me.**

Parent's Signature____ Date_____________



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PUBLICATION RELEASE FORM

During the school year, your student may have the opportunity to have his/her photograph(s) and/or schoolwork published in the district, school, and/or local news publications, and/or displayed on the district/school Web sites and social media accounts (District Instagram, Facebook, or Twitter accounts). Publishing or displaying student photographs and schoolwork furthers the school's educational mission and permits you, the parent or guardian, along with other friends or relatives of the child, to view your child's accomplishments.

Your child's name: ____
(first and last name of child)

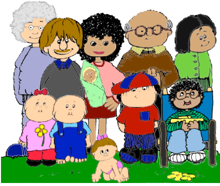
Please check one:

❑ Yes, I give permission to allow my child to be photographed/videotaped and to use his/her first name in publications.

❑ No, I do not give permission to allow my child to be photographed/videotaped and to use his/her first name in publications.

Signature of Parent: ____ Date: ____________________

Please note that if your child participated in public events (such as a sporting event or drama production that is open to the community) the school/district may have little or no control over photographs taken by media, other parents, or community members attending the events.



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10319 Firmona Avenue, Lennox CA 90304
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HEALTH HISTORY FORM

(To be filled out by parents only)

Child's Name ____ Grade: ____________

Date of Birth: ___________________ Gender: ☐ Male ☐ Female School: __________________

Child's Birth Order (1,2,3,etc.) _____ Name of Parents: _________________________________

Phone Number: _________________ Address:_____________________________________

1. Maternal & Infant History:

Maternal & Infant History:

A. Maternal History

Complications of Pregancy: No____ Yes____ Specify: ______________________________

B. Infant History

Condition of Newborn: _____________________________ Birth weight: _____lb. ____oz.

1st month complications: No ___ Yes ___ Specify: ________________________________
Duration: Pregnancy ____months Labor: ____hours Delivery Method: ______________
Medication/Drug taken during pregnancy? No ___ Yes ____ Specify: _________________

2. Past Medical History and Illinesses: (Circle Y for Yes and N for No)

Allergies	Yes	No	Measles	Yes	No	Heart Disease	Yes	No
Anemia	Yes	No	Chicken Pox	Yes	No	Kidney Disease	Yes	No
Asthma	Yes	No	Mumps	Yes	No	Meningitis	Yes	No
Diabetes	Yes	No	Rubella (3 days measles)	Yes	No	Sickle Cell	Yes	No
Drug Allergy	Yes	No	Scarlet Fever	Yes	No	Convulsions/Epilepsy	Yes	No
Ear Problems	Yes	No	Whooping Cough	Yes	No	Rheumatic Fever	Yes	No
Eye Problems	Yes	No	Tuberculosis	Yes	No	Hepatitis B	Yes	No
Frequent Colds	Yes	No	Polio	Yes	No	HIV/AIDS	Yes	No
Sore Throats	Yes	No	Diphtheria	Yes	No	Alcoholism	Yes	No
Wheezing	Yes	No	Pneumonia	Yes	No	Smoking	Yes	No
High Blood Pressure	Yes	No	Hospitalization/ Surgeries	Yes	No	Substance Abuse	Yes	No

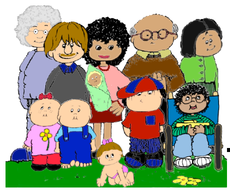
3. Family History (circle Yes or No)

Rheumatic Fever	Yes	No	Syphilis	Yes	No	Mentally Challenge	Yes	No
Tuberculosis	Yes	No	Bleeding Disorder	Yes	No	Mental Disease	Yes	No
Diabetes	Yes	No	Jaundice	Yes	No	Obesity	Yes	No
Epilepsy	Yes	No	Kidney Disease	Yes	No	Birth Defects	Yes	No
Cancer	Yes	No	Asthma	Yes	No	Hepatitis B	Yes	No
High Blood Pressure	Yes	No	Anemia	Yes	No	HIV/AIDS	Yes	No
Heart Disease	Yes	No	Allergies	Yes	No	Alcoholism	Yes	No
Smoking	Yes	No	Substance Abuse	Yes	No	If "Yes" specify family member condition: ______		

4. General Health: Family (Mark with X)

	Good	Fair	Poor	Briefly explain:
Mother	_____	_____	_____	______________________________
Father	_____	_____	_____	______________________________
Siblings	_____	_____	_____	______________________________

Parent's Singature : ___________________________________ Date: __________________



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STUDENT NIGHTTIME RESIDENCY QUESTIONNAIRE

This questionnaire is intended to address the McKinney-Vento Act, U.S.C.A Section 11302(a). Your answers will help the school determine residency documents necessary for enrollment and services to which you may be eligible.

Date: ______________________ School: ____ Student ID# ____________________

Student Name (First, MI, Last: ____ ☐Male ☐Female

Date of Birth: ______________________ Grade: PREK Special Ed: ☐NO ☐YES, designation __________________________________

Address:____ City: ____________________________ Zip:______________

Mailing Address (if different):____

Parent/Guardian Name: ____Contact Number: _________________________

The student(s) live(s) with: ☐1 parent ☐1 parent & another adult ☐an adult that is not the parent/guardian
☐2 parents ☐a relative ☐alone with no adults

Student's Living Situation (Check all that may apply):

- ☐ (100) In a shelter ______________________________(name of shelter)
- ☐ (110) In a motel or hotel ______________________________(name of motel/hotel)
- ☐ (210) In a transitional housing program ______________________________(name of program)
- ☐ (130) In a car, trailer or campsite, **temporarily**, **due to inadequate housing**
- ☐ (130) In a rented trailer/motor home on private property
- ☐ (120) In a Single Room Occupancy (SRO) building – a multiple tenant building consisting of individual rooms with shared restrooms and kitchens
- ☐ (130) In a rented garage, **temporarily, due to loss of housing**
- ☐ (120) In another family's house or apartment, **temporarily, due to loss of housing**, stemming from financial problems (e.g. loss of job, eviction, or natural disasters)
- ☐ (120) With an adult that is not the parent/legal guardian, **temporarily, due to loss of housing**
- ☐ (130) Other places not designed for, or ordinarily used as a regular sleeping accommodation for human beings (please explain)____
- ☐ Living alone, without any adult (unaccompanied youth)

☐ **None of the above apply** – NO FURTHER INFORMATION REQUIRED AT THIS TIME. If YOUR HOUSING SITUATION CHANGES, PLEASE NOTIFY YOUR CHILD'S SCHOOL.

Please list all siblings between the ages of birth and 22 years old.

NAME	DOB	AGE	GRADE	SCHOOL

By signing this form, I declare under penalty of the laws in the State of California that the foregoing is true and correct. In addition, I understand that the District reserves the right to verify and above listed residence information.

Signature of Parent/Legal Guardian/Caregiver: ____ **Date:** ______________________

PHYSICIAN'S REPORT – SCHOOL 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 BIRTHDATE

the LENNOX SCHOOL READINESS PROGRAM. This Child Care Center/School provides a program, which extends from 8:30 am to
NAME OF SCHOOL

10:00 am, 10:30 am to 12:00 pm or 1:00 pm to 2:30 pm ***two*** 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 **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:

Other (Include behavioral concerns):

Dental:

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: **IMMUNIZATION HISTORY:**

(Fill out or enclose California Immunization Record, PM – 298.) (If the vaccines are not written on this form please provide a print out)

Vaccine	Date Each Dose Was Given				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)					
DTP/DtaP/DT/Td					
MMR (Measles, Mumps, and Rubella)					
HIB Meningitis (Required for Child Care Only)					
Hepatitis B					
Varicella Chickenpox)					
Hepatitis A					
Pnuemocococcal					

☐ **Tuberculosis Test done on**: ______________ ☐ **No Risk Factor** Date Given: __________ Date Read:__________ Results ______

Have ☐ Have not ☐ reviewed the above information with the parent/guardian.

Physician:	Date of Physical Exam:	
Stamp:	Date this Form Completed:	
	Signature:	

Form completed by:	☐ Physician	☐ Physician's Assistant	☐ Nurse Practitioner