



[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]







# WCCUSD State Preschool / 2016-2017 Special Needs/Services List

**Special Needs/Services**  
(Please check all that apply)

**YES**

**NO**

**Parent/Guardian Comments**

DOC.  
ached



**WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT**

Office of Educational Services  
Early Learning Programs  
1108 Bissell Avenue  
Richmond, California 94801  
Telephone: (510) 307-4585 Fax (510) 237-1536  
Email: nreschool@wccusd.net

Nia Rashidchi

Janet Scott, Ed.D.

Olanrewaju Ajayi

**STATE PRESCHOOL PROGRAM**

**ADMISSION AGREEMENT**

The Admission Agreement between the West Contra Costa Unified District and the parent/guardian of the child/children attending the State Preschool Program is considered contractual and binding.



**WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT  
DECLARATION OF RESIDENCE**

\_\_\_\_\_, under penalty of perjury, declare as follows:

Address

City/State

Zip

Date

Address

City/State

Zip Code

Residing with \_\_\_\_\_

Name of Homeowner

- My minor child (ren) \_\_\_\_\_ will reside with me at that address for the \_\_\_\_\_ school year.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT





**WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT**

**Office of Educational Services**

**Child Care Data Collection  
Privacy Notice and Consent Form**

The United States Department of Health and Human Services (HHS) is gathering information about

family child care assistance. The information is used to determine the amount of assistance that a family is eligible to receive.

[Redacted]

[Redacted]

[Redacted]

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[Redacted]

[Redacted]

COMMUNITY CARE LICENSING DIVISION

**CHILD CARE CENTER  
NOTIFICATION OF PARENTS' RIGHTS**

**PARENTS' RIGHTS**

As a Parent/Authorized Representative, you have the right to:

## 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

(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

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**GENERAL RELEASE**

Photographs, Videotaping, Interview Comments, and Posting on the Internet

EQ:

Revised and Clarified

[Redacted]

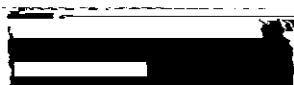
[Redacted]

[Redacted]

**Community Resources**

LAO FAMILY COMMUNITY DEVELOPMENT.....510-215-1220  
REFERRALS/COUNSELING

FAMILIAS UNIDAS COUNSELING CENTER.....510-412-5930  
TRANSLATING, JOB REFERRALS, FOOD, COUNSELING







Room #

is essential in  
addition,

Age

Sex

Phone Number

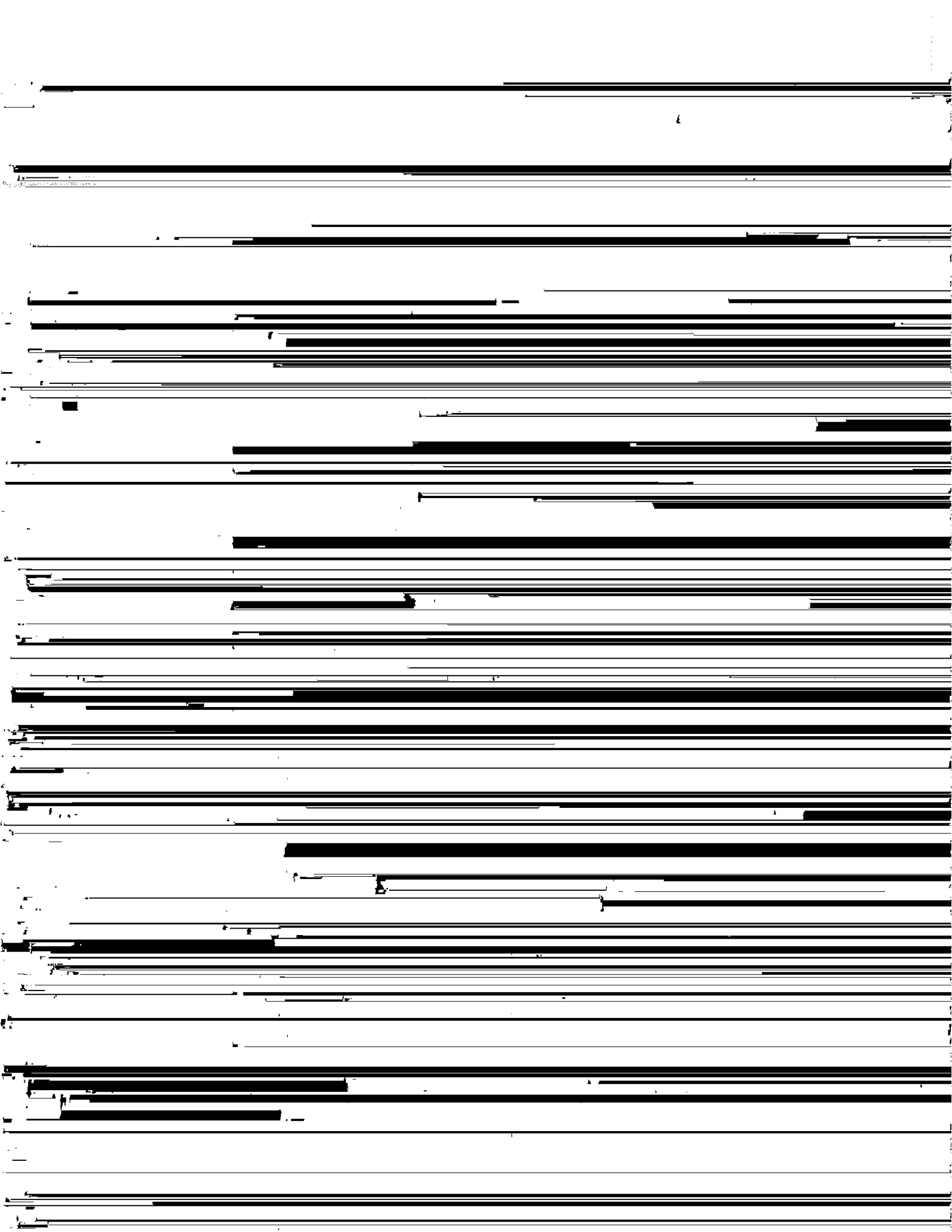
only language listed.)

school name

English OR the

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









WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT

Food Services Department

750 Bissell Ave, Richmond, CA 94801

Tel: (510) 307-4580

Fax: (510) 233-1805

2016-17 MEDICAL STATEMENT - REPORTE MEDICO

FOR CHILDREN REQUIRING DIETARY RESTRICTIONS OR MODIFICATIONS DUE TO ALLERGIES OR CHRONIC DISEASES

Para Niños quienes requieren Restricciones o Modificaciones Dietéticas a causa de Alergias o Enfermedades Crónicas

NAME OF STUDENT/Nombre del Estudiante	BIRTHDATE/ Fecha de Nacimiento
NAME OF PARENT or GUARDIAN/Nombre del Padre, Madre o Tutor	PHONE NUMBER/Número de Teléfono

MY CHILD HAS ALLERGIES

This medical statement doesn't need to be completed if your child DOESN'T have

# WCCUSD STATE PRESCHOOL



## CONSENT FOR EMERGENCY MEDICAL TREATMENT

As the parent or authorized representative, I hereby give consent to **WCCUSD State Preschool** to obtain all emergency Medical or Dental Care prescribed by a duly licensed physician (M.D.) Osteopath (D.O.) or Dentist (D.D.S) for \_\_\_\_\_ . This care may be given under whatever conditions are necessary to preserve the life, limb, or well being the child named above.

My Child has the following medication allergies: \_\_\_\_\_

My Child **does not have** any medication allergies

\_\_\_\_\_ Date

**X** \_\_\_\_\_ Parent or Authorized Representative Signature

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

### ASTHMA Questionnaire

My child does not have asthma

[REDACTED]



CHILD'S PREADMISSION HEALTH HISTORY- PARENT'S REPORT

CHILD'S NAME

SEX

BIRTH DATE

[The page contains multiple lines of text that have been completely redacted with black bars.]

**REPORTE DEL MEDICO CUADRENIAS INFANTILES**