

PRESCHOOL REGISTRATION



- Children must be 3 years of age by September 1st
- Free for qualifying families
- Tuition options available for overincome families
- Dual immersion programs available
- Part Day Programs - 8am to 11am or 12pm to 3pm
- Full Day Programs - 8am to 4pm

714.431.7580

Register Now!! ¡¡Inscribiendo Ahora!!

www.sausd.us/ece

INSCRIPCIÓN PRESCOLAR

- Los niños deben tener 3 años de edad para el 1 de septiembre
- Gratis para las familias que califican basados en sus ingresos
- Programa de paga disponible
- Programas de Inmersión Dual
- Programas de Día Parcial - 8am a 11am o 12pm a 3pm
- Programas de Día Completo - 8am a 4pm

ECE
Early Childhood Education



SANTA ANA UNIFIED SCHOOL DISTRICT - EARLY CHILDHOOD EDUCATION - 1629 S. CENTER STREET - SANTA ANA, CA
OFFICE HOURS: M-F 7:30AM-4:00PM 714.431.7580 PHONE - 714.431.7596 FAX



**EARLY CHILDHOOD EDUCATION
PRE-ELIGIBILITY APPLICATION
2019-2020**

Early Childhood Education

Agency Use Only	
Child ID:	_____
Family ID:	_____
Received by:	_____
Date:	_____

Note: This is a preliminary application. It does not guarantee your child's placement in the program. Children must be 3 years old by Sept. 1st of the school year they start. *Meals at No Charge to Parents* Parents may drop off preliminary application at 1629 S. Center St., Santa Ana, CA 92704; Monday –Friday 7:30am-4:00pm

FAMILY INFORMATION

Part Day Full Day* DUAL

Child's First, M., Last Name: _____ Date of Birth: _____ Male Female

Father's First, M., Last Name: _____ Phone Number: _____

Mother's First, M., Last Name: _____ Phone Number: _____

Home Phone Number: _____ Email: _____

Home Address: _____ City, Zip Code: _____

Child Lives with: Both Parents Mother Only Father Only Legal Guardian

Is your child receiving any type of special needs service? (ie: Speech Therapy, Occupational Therapy, etc.) Yes No

Does Child have an IEP? Yes No

How did you hear about us? _____ **Any Court or Restraining Orders?** Yes No

Please check the school of your choice:

- Carver Davis* Diamond Esqueda* Franklin* Fremont Garfield* Harvey* Heninger* Hoover
 Heroes Jefferson* King* Lowell Lincoln* Madison* Martin Mitchell Monroe* Pio Pico*
 Santiago* Romero-Cruz* Roosevelt Ctr*(Walker) Taft Warwick Washington* Wilson*

OTHER CHILDREN LIVING IN YOUR HOME AND UNDER YOUR CARE – 18 years and younger

Last Name	First Name	Date of Birth	School Attending	Grade

FATHER'S GROSS INCOME-One month of consecutive and recent paycheck stubs/ledgers must be submitted with this questionnaire

Company Name	Receives Payment:	Gross Amount Per Pay Period	Cash or Check
	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Twice-Monthly		<input type="checkbox"/> Cash <input type="checkbox"/> Check
	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Twice-Monthly		<input type="checkbox"/> Cash <input type="checkbox"/> Check

MOTHER'S GROSS INCOME-One month of consecutive and recent paycheck stubs/ledgers must be submitted with this questionnaire

Company Name	Receives Payment:	Gross Amount Per Pay Period	Cash or Check
	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Twice-Monthly		<input type="checkbox"/> Cash <input type="checkbox"/> Check
	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Twice-Monthly		<input type="checkbox"/> Cash <input type="checkbox"/> Check

OTHER INCOME SOURCES – Please select all that apply to you.

Unemployment \$ _____ Child Support \$ _____ TANF/CalWORKs/Cash Aide: \$ _____
 Foster Parent: \$ _____ Spousal Support \$ _____ Cal Fresh # _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

FOR AGENCY USE ONLY. DO NOT WRITE BELOW THIS LINE

Date/Notes/Initials: _____	Rank: _____	Family Size: _____
Date/Notes/Initials: _____	Gross Income: _____	
Date/Notes/Initials: _____	DOB Eligible: _____	
Date/Notes/Initials: _____	Verified By/Date: _____	



**PROGRAMA DE EDUCACIÓN TEMPRANA INFANTIL
 APLICACION DE ELEGIBILIDAD
 2019-2020**

Early Childhood Education

Agency Use Only	
Child ID:	_____
Family ID:	_____
Received by:	_____
Date:	_____

Nota: Esta es una aplicación preliminar. No garantiza que su hijo/a tenga un lugar asegurado en el programa. Los niños deben tener 3 años de edad para el día 1 de septiembre del año escolar en el que inician. Los padres pueden llevar la solicitud preliminar al 1629 S. Center St., Santa Ana, CA 92704.

INFORMACION DE LA FAMILIA

Parte Día Día Completo* Dual

Nombre Completo del Niño: _____ Fecha de Nacimiento: _____ Masculino Femenino
 Nombre Completo del Padre: _____ Número de Teléfono: _____
 Nombre Completo de la Madre: _____ Número de Teléfono: _____
 Teléfono de Casa: _____ Correo Electrónico: _____
 Dirección: _____ Ciudad/Código Postal: _____

¿Está recibiendo su hijo/a algún tipo de servicios de necesidades especiales?

Niño vive con: Dos Padres Solamente Madre (ie: Terapia de Habla, Terapia Ocupacional etc.) Sí No

Solamente Padre Guardián Legal ¿Tiene su hijo/a un IEP? Sí No

¿Como se enteró acerca de nosotros? _____ **Tienen Orden de Corte o Orden de Restricción?** Sí No

Por favor marque la escuela de su elección:

- Carver Davis* Diamond Esqueda* Franklin* Fremont Garfield* Harvey* Heninger* Hoover
 Heroes Jefferson* King* Lowell Lincoln* Madison* Martin Mitchell Monroe* Pio Pico*
 Santiago* Romero-Cruz* Roosevelt Ctr*(Walker) Taft Warwick Washington* Wilson*

OTROS HIJOS QUE VIVEN EN LA MISMA CASA Y QUE ESTEN BAJO SU CUIDADO – Menores de 18 años

Apellido	Nombre	Fecha de Nacimiento	Escuela	Grado

INGRESOS BRUTOS DEL PADRE—Un mes de sueldo consecutivos y talones de cheques recientes deben presentarse con este cuestionario

Nombre de la Compañía	Recibe Pago	Ingresos Bruto Por Periodo	Efectivo o Cheque
	<input type="checkbox"/> Semana <input type="checkbox"/> 2 Semanas <input type="checkbox"/> Mes <input type="checkbox"/> 2 veces al Mes		<input type="checkbox"/> Efectivo <input type="checkbox"/> Cheque
	<input type="checkbox"/> Semana <input type="checkbox"/> 2 Semanas <input type="checkbox"/> Mes <input type="checkbox"/> 2 veces al Mes		<input type="checkbox"/> Efectivo <input type="checkbox"/> Cheque

INGRESOS BRUTOS DE LA MADRE—Un mes de sueldo consecutivos y talones de cheques recientes deben presentarse con este cuestionario

Nombre de la Compañía	Recibe Pago	Ingresos Bruto Por Periodo	Efectivo o Cheque
	<input type="checkbox"/> Semana <input type="checkbox"/> 2 Semanas <input type="checkbox"/> Mes <input type="checkbox"/> 2 veces al Mes		<input type="checkbox"/> Efectivo <input type="checkbox"/> Cheque
	<input type="checkbox"/> Semana <input type="checkbox"/> 2 Semanas <input type="checkbox"/> Mes <input type="checkbox"/> 2 veces al Mes		<input type="checkbox"/> Efectivo <input type="checkbox"/> Cheque

OTROS INGRESOS – Por favor, marque todas las que recibe

Desempleo: \$ _____ Manutención de los hijos: \$ _____ TANF/CalWORKs/Ayuda Monetaria: \$ _____
 Padre de Crianza: \$ _____ Manutención de esposo/a: \$ _____ # de Cal Fresh _____

FIRMA DEL PADRE/TUTOR: _____ FECHA: _____

FOR AGENCY USE ONLY. DO NOT WRITE BELOW THIS LINE

Date/Notes/Intials:	Rank:	Family Size:
Date/Notes/Intials:	Gross Income:	
Date/Notes/Intials:	DOB Eligible:	
Date/Notes/Intials:	Verified By/Date:	



Early Childhood Education



School Site: _____ AM PM

Student Name: _____ M F

Date of Birth: _____ Phone: _____

Parent/Guardian's Name: _____

DOCUMENTS NEEDED WITH YOUR PRESCHOOL APPLICATION:

1 – PROOF OF INCOME (Provide ONE of the following)

- 1 month's recent & consecutive paycheck stubs
- Cash Aid
- Child Support
- Unemployment
- Disability
- SSI

2 – FAMILY SIZE DOCUMENTATION (Provide ONE of the following for ALL children in the family)

- Birth certificate
- Hospital registration
- CPS letter
- Adoption documents
- Foster/Legal guardian letter

OTHER DOCUMENTATION THAT WILL BE REQUESTED:

CHILD REQUIREMENTS (Provide ALL of the following for the child you are enrolling)

- Physical exam (attached)
- Dental exam (attached)
- Immunization records (yellow card, blue card or physical form from doctor)

ADULT VOLUNTEER REQUIREMENTS (Provide ALL of the following) – *PART DAY ONLY!*

- Current TB test (within last 12 months)
- Photo Identification
- Proof of immunization for:
 - Influenza
 - Pertussis
 - Measles

1629 Center St, Santa Ana, CA 92704

714-431-7580 Phone

714-431-7596 FAX

Office Hours: M-F 7:30am-4:00pm



Programa de Educación Temprana



Escuela: _____ AM PM

Nombre del niño/a: _____ M F

Fecha de Nacimiento: _____ Teléfono: _____

Nombre del Padre/Tutor _____

DOCUMENTOS NECESARIOS CON SU APLICACIÓN DE ELEGIBILIDAD:

1 – COMPROBANTE DE INGRESOS (Adjunte UNO de los siguientes)

- 1 mes de ingresos recientes y consecutivos - *talones de cheque*
- Asistencia Monetaria
- Manutención
- Desempleo
- Incapacidad
- SSI

2 – DOCUMENTACION DE TAMAÑO DE LA FAMILIA (Adjunte UNO de los siguientes para cada uno de sus hijos menores de 18 años)

- Certificado de Nacimiento
- Registro del Hospital
- Carta de CPS
- Documentos de adopción
- Carta de Hijo de Crianza/Tutor Legal

OTRA DOCUMENTACION QUE SERA SOLICITADA:

REQUISITOS DEL NIÑO/A (Adjunte todo lo siguiente)

- Examen Físico
- Examen Dental
- Tarjeta de Vacunas y Prueba de tuberculosis

REQUISITOS DE LOS ADULTOS VOLUNTARIOS (Adjunte todo lo siguiente) – **SOLAMENTE PARTE DIA!**

- Prueba de tuberculosis (dentro de los últimos 12 meses)
- Identificación con foto
- Prueba de vacunas:
 - La Gripe
 - Tosferina
 - Sarampión

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**SANTA ANA UNIFIED SCHOOL DISTRICT
EARLY CHILDHOOD EDUCATION PROGRAM**



Physical Exam

CENTER _____ TEACHER _____ AM PM FD
 CHILD _____ ADDRESS _____
 D.O.B. _____ PHONE _____
 CHDP Exam YES NO MEDICAL PLAN NAME _____

VISION RESULTS

PASSED R20/ _____ L20/ _____
 FAILED R20/ _____ L20/ _____
 UNABLE TO CONDITION
 REFERRED TO _____

AUDIOMETRY RESULTS

PASSED R _____ L _____
 FAILED R _____ L _____
 UNABLE TO CONDITION
 REFERRED TO _____

REQUIRED TB ASSESSMENT

(MUST BE WITHIN 12 MO OF STARTING SCHOOL)
NO RISK FACTORS OR
 PPD DATE GIVEN _____
 PPD DATE READ _____
 MM INDURATIONS _____

GENERAL HEALTH

LENGTH/HEIGHT _____ WEIGHT _____
 BLOOD PRESSURE _____
 LEAD SCREEN _____
 URINE DIP/URINALYSIS _____

CALIFORNIA STATE REQUIRED IMMUNIZAIONS

	Polio	Dtap	MMR	Hib	Hep B	Pneu
1	/ / /	/ / /	/ / /	/ / /	/ / /	/ / /
2	/ / /	/ / /	/ / /	/ / /	/ / /	/ / /
3	/ / /	/ / /	Varicella	/ / /	/ / /	
4	/ / /	/ / /	/ / /	/ / /	Hep A	
5	/ / /	/ / /	/ / /	/ / /	/ / /	

PHYSICAL EXAMINATION

	NORM	ABNORM		NORM	ABNORM		NORM	ABNORM
GEN. APPEARANCE			GLANDS			MUSCULAR COORDIN.		
POSTURE/GAIT			HEART			MOTOR ABILITY		
SPEECH			LUNGS			SELF/HELP SOCIAL SKILLS		
HEAD/NECK			ABDOMEN			COMMUNICATION SKILLS		
EYES			GENITALIA			COGNITIVE SKILLS		
EARS			BONES/JOINTS/MUSCLE			FLUORIDE PRESCRIBED	<input type="checkbox"/> YES	<input type="checkbox"/> NO
NOSE			SKIN			OTHER <input type="checkbox"/>		
MOUTH/TEETH			BACK					

PLEASE EXPLAIN ANY ABNORMAL FINDINGS/ GENERAL STATEMENT ABOUT CHILD'S HEALTH

ASTHMA/ALLERGY Yes No Requires Medication at School Yes No Epi-Pen Inhaler Other _____

If medication is required at school, please complete the medication at school form.

REFERRED TO _____ FOR _____

PHYSICIAN INFORMATION

DOCTOR'S NAME _____
 PRINT SIGNATURE DATE
 DOCTORS ADDRESS _____ PHONE _____



SANTA ANA UNIFIED SCHOOL DISTRICT
Early Childhood Education Program



SITE _____
 1629 S. Center St.
 Santa Ana, CA 92704

REQUIRED DENTAL EXAMINATION FORM

Name of Child _____ Date of Birth _____

Dental Insurance _____

Name of Parent(s) _____ Phone number _____

To the Dentist

The above named child is participating in the Early Childhood Education program and is required to submit evidence of a dental examination performed within the last six months. After the examination results are recorded, please return the completed form to the parent.

DATE OF EXAM _____ DATE OF NEXT APPOINTMENT IF REQUIRED _____

	Please Indicate All Applicable Statements	Check Below
1	X-Rays, Examination and Diagnosis, Prophylaxis and Topical Fluoride	
2	No Treatment needed	
3	Surface Filling (number needed)	
4	Stainless Steel Crown (number needed)	
5	Pulpotomy (number needed)	
6	Extraction (number needed)	
7	Other (specify)	

Status of Treatment

Completed Not Completed *Explain:* _____

Name of Dentist _____

Date _____

Dentist's Address: _____

Dentist's Signature _____

Dentist's Phone number _____

Dentist Stamp Here

White Copy = Child's File

Yellow Copy = Parent

