Acknowledgment

Child's Name _____

I wish to acknowledge that I received, read and understand the contents of the Preschool Services Department EHS Parent Handbook. As a parent or guardian of a child enrolled in the EHS Program, I will follow the policies and procedures, as detailed in the Parent Handbook. I will also work collaboratively and in partnership with the EHS staff to ensure compliance with local, state and federal regulations as required in the daily operation of the programs offered for young children.

I have received:
An orientation for parents which includes program philosophy, program goals and objectives, program activities, eligibility requirements, and

- Due process procedures ☐
- Parent rights ☐
- Personal rights ☐

_____ _____

Parent / Guardian Signature Date

Please place a copy in child's folder.

PRESCHOOL SERVICES DEPARTMENT

COUNTY OF SAN BERNARDINO

FOOD ALLERGY QUESTIONNAIRE

Child's name:_____ Center:_____

Child is allergic to: _____

Does your child have Lactose Intolerance or Milk Allergy?

What food other than milk is your child allergic to?

What symptoms occur when the child eats these foods?

Can an allergic reaction threaten breathing or threaten you child's life?

(Yes or No and please give details)

Please list any specific foods that you know the child should avoid (foods which may have the allergen as a hidden ingredient):

Which food substitutions should your child have instead of what is on the menu?

Does your child need to have medication at school in case of an allergic reaction?

Yes or No-please give details concerning medication: (if yes, please ask Site Supervisor for the Medication Forms to take to you doctor)

Parent Signature:_____ Date:_____

Note: Please fax this form with the Medical Statement to the Nutritionist at 909.383.2086

Acknowledgment

Child's Name _____

I wish to acknowledge that I received, read and understand the contents of the Preschool Services Department EHS Parent Handbook. As a parent or guardian of a child enrolled in the EHS Program, I will follow the policies and procedures, as detailed in the Parent Handbook. I will also work collaboratively and in partnership with the EHS staff to ensure compliance with local, state and federal regulations as required in the daily operation of the programs offered for young children.

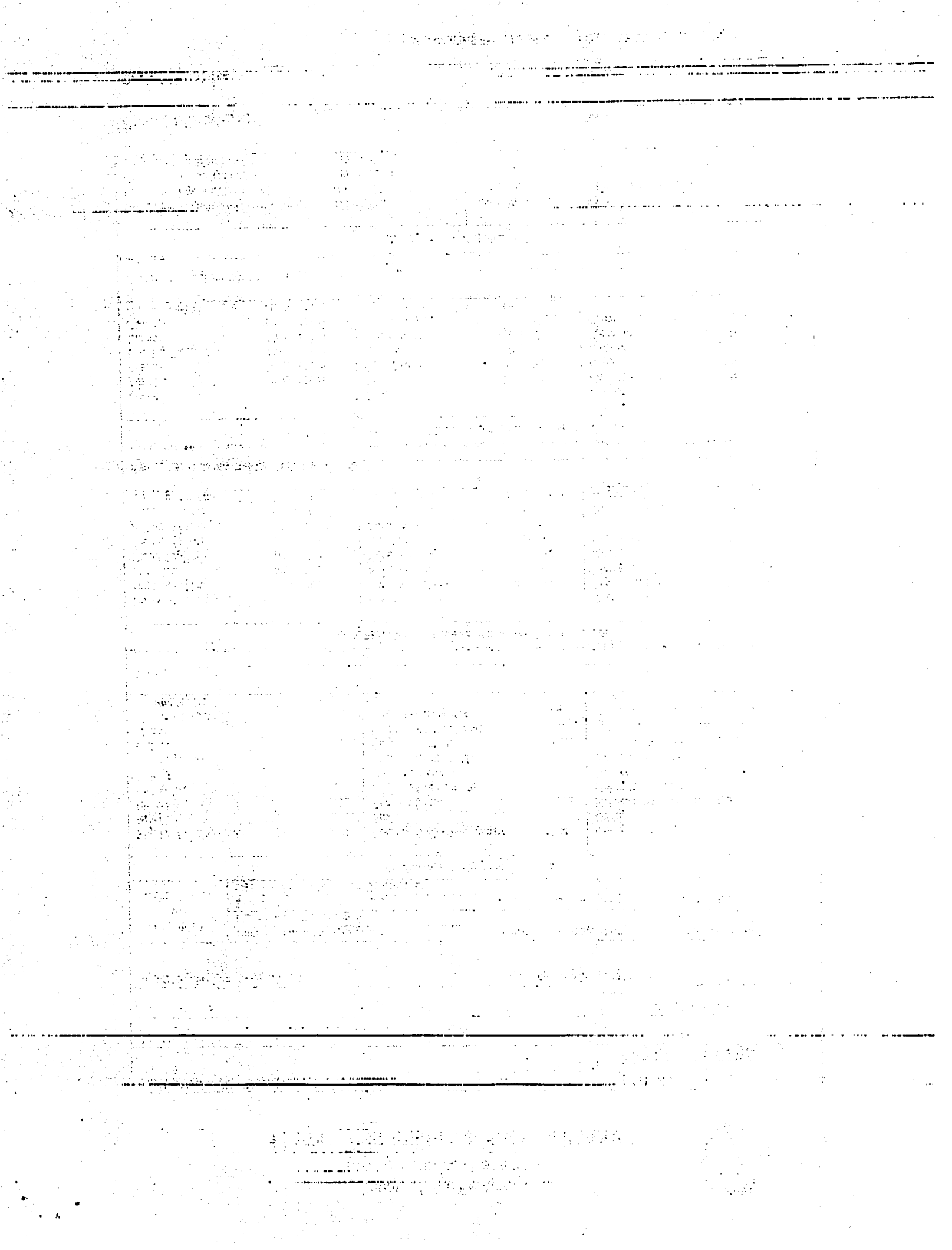
I have received:
An orientation for parents which includes program philosophy, program goals and objectives, program activities, eligibility requirements, and

- Due process procedures ☐
- Parent rights ☐
- Personal rights ☐

_____ _____

Parent / Guardian Signature Date

Please place a copy in child's folder.



County of San Bernardino
Preschool Services Department

Home Visit Initiative Health History

Print Last Name, First Name, Middle Name	M □ F □	Date of Birth: Birth Order : 1 2 3 4 Other: ( )
Address: Apt #: City:		Zip:
Daytime Phone: Alternate Phone:		Dental Insurance: □ Yes □ No Name:
Medical Home (Address and Phone)		Dental Home (Address and Phone)

Obstetrical and Neonatal History	Number of months of pregnancy: Month prenatal care began: Birth Weight: _____lbs _____oz Delivery Method: Vaginal □ Cesarean □	Specify complications of pregnancy: (If none, write "None.") Specify neonatal pregnancy: (If none, write "None.")

Development History (indicate month)

Physical Development:	Month	Personal Social Development:	Month:	Language Development:	Month:
Grasping	____	Smiles	____	Cooing	____
Reaching	____	Reaches for toys	____	Imitates sounds (i.e. dada, mama)	____
Rolling Over	____	Plays (ball, pat-a-cake)	____	Makes specific sounds	____
Sitting Up	____	Drinks from cup	____	1-2 word sentences	____
Creeping & Crawling	____	Uses spoon, spills little	____	2-3 word sentences	____
Walking	____	Removes clothing	____	Developmental concerns: _____	
Weaning		Washes and dries hands	____		
From breast	____	Dresses with supervision	____		
From bottle	____				

Additional Concerns: _____

Child's Past Medical History and Illnesses (X applicable box)

Illness/Condition:		Illness/Condition:		Illness/Condition:	
Hospitalizations	No □ Yes □	Speech Problems	No □ Yes □	Any Birth Defects	No □ Yes □
Surgeries	No □ Yes □	Frequent Colds	No □ Yes □	Chicken Pox	No □ Yes □
Drug Allergies	No □ Yes □	Ear Infections	No □ Yes □	Mumps	No □ Yes □
Allergies (other)	No □ Yes □	Sore Throat	No □ Yes □	Red Measles	No □ Yes □
Asthma/Wheezing	No □ Yes □	Pneumonia	No □ Yes □	Rubella	No □ Yes □
Visual Problems	No □ Yes □	Heart Disease	No □ Yes □	Tuberculosis (TB)	No □ Yes □
Learning Problems	No □ Yes □	Kidney Disease	No □ Yes □	Whooping Cough	No □ Yes □

If yes, please add any additional information here: _____

Family History (X applicable box and describe in designated space)

Condition:		Condition:		Condition:	
Allergies	No □ Yes □	Epilepsy	No □ Yes □	Mental Retardation	No □ Yes □
Anemia	No □ Yes □	Heart Disease	No □ Yes □	Rheumatic Fever	No □ Yes □
Bleeding Disorder	No □ Yes □	Hepatitis	No □ Yes □	Smoking	No □ Yes □
Cancer	No □ Yes □	Hypertension	No □ Yes □	Tuberculosis (TB)	No □ Yes □
Diabetes	No □ Yes □	Kidney Disease	No □ Yes □	Communicable Disease	No □ Yes □
Drug/Alcoholism	No □ Yes □	Mental Illness	No □ Yes □		

If yes, please add any additional information here: _____

Dental History (X applicable box)

Use a wash cloth to wipe infant's gums? No □ Yes □	Any dental problems? No □ Yes □
Do you brush your child's teeth? No □ Yes □	If yes, please add any additional information here: _____
Use fluoride or toothpaste? No □ Yes □	
Use fluoride supplements? No □ Yes □	

Parent Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

PRESCHOOL SERVICES DEPARTMENT OF SAN BERNARDINO COUNTY
662 S. Tippecanoe Ave, San Bernardino, California, 92415-0630
(909) 383-2050

Home Visitation Initiative
PERMISSION FOR RELEASE OF INFORMATION

Child's Name:_____ Date of Birth:_____

Address:_____ Site:_____

City:_____ Zip:_____ Telephone:_____

I give Preschool Services Department of San Bernardino County permission to obtain from or give to the following persons or agencies pertinent medical, developmental, social or other information about my child. I understand that such information will remain confidential to all other parties and that such information will be used only to give my child the best available professional services.

Name of Agencies and/or Person: (Include agency name, address, and phone number)

_____
Agency name

_____
Address

_____
City/State/Zip

_____
Telephone

_____
Agency name

_____
Address

_____
City/State/Zip

_____
Telephone

_____
Parent/Guardian Signature

_____
Date Signed

This consent shall remain effective for one year following the date of signature. A copy of this is as valid as the original.

SCREENING CONSENT FORM

Child's Name_____ Date_____

I give my permission to the San Bernardino County Preschool Services Department and its contracted Community Partners to perform or obtain the following:

- Medical Authorization
- Vision Screening (Eyes)
- Hearing Screening (Ears)
- Height/Weight Screening
- Non-invasive Hemoglobin Screening
- Dental Screening and Topical Fluoride Application
- Developmental Screening (Learning): ASQ-3
- Social/Emotional Screening: Ages & Stages (ASQ-SE)
- Desired Results Developmental Profile (DRDP)
- Home Visit Rating Scales (HOVRS - Home Base Program)

Signature of Parent/Guardian _____ Date

Signature of PVP Staff _____ Date

San Bernardino County
Preschool Services Department
662 S. Tippecanoe Ave
San Bernardino, CA 92415-0630

HVP
SCREENING CONSENT FORM
2020/2021

Child's Name_____ Center_____

With your permission, a number of routine screenings will be performed while your child is enrolled in the Home Visitors Initiative Program. The purpose of these screenings is to assess the general health and development of your child and to identify any health and/or development concerns. If our screenings indicate that further evaluation, medical examination or treatments are needed; we will contact you and will assist you in the follow-up process.

I give my permission to the San Bernardino County Preschool Services Department and to its contracted Community Partners to perform or obtain the following:

- Medical Authorization
- Vision Screening (Eyes)
- Hearing Screening (Hearing)
- Height/Weight Screening
- Non-invasive Hemoglobin Screening
- Dental Screening and Topical Fluoride Application
- Developmental Screening (Learning): ASQ 3
- Social/Emotional Screening: Ages & Stages (ASQ-SE)
- Desired Results Developmental Profile + Assessment
- Home Visit Rating Scales (HOVRS - Home Base program only)

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of HVP Staff Date

County of San Bernardino Preschool Services Department

McKinney-Vento Assistance Act
Parent Questionnaire

Please complete the following information about your housing. All information will be treated confidentially. No information will be shared with other agencies without your permission.

If your family does not live in any of the listed conditions, please return the form anyway, marking "none of the above." Thank you.

Name of Parent/Legal Guardian: _____

Date: _____

Name of enrolling child: _____

School: _____

Where does the family currently live? Please check all that apply:

- ☐ Own a home
- ☐ Rent our home or apartment
- ☐ Live in a rented room
- ☐ Live in a hotel/motel*
- ☐ Live in a garage, abandoned building or other similar location
- ☐ Live in a shelter*
- ☐ Live in a car, van, or on the street
- ☐ Live with another family for financial reasons*
- ☐ Live in a tent or vehicle at a campground
- ☐ None of the above. Please explain: _____

_____

_____

* Provide documentation/statement from hotel/motel/shelter or other family to verify living situation. Must attach the PSD Home Visitor Initiative Third Party Consent

_____ _____

Parent/Guardian Signature Date

County of San Bernardino
Preschool Services Department

Picture Consent Form

I, _____ give permission for my child _____
Parent/Guardian Child's Name

To be photographed/media/video taped during school activities.

_____ _____
Date Signature Parent/Guardian

Getting to know your family, Continued

Your family's health and safety

My Family sees a doctor/dentist:
☐ Not often ☐ When we are sick ☐ For checkups

My Family makes a meal at home
☐ 0-3 times a week ☐ 4-7 times a week ☐ 8 or more times a week

I feel safe where I live
☐ No ☐ Somewhat ☐ Yes

I can buy what I need
☐ Rarely ☐ Sometimes ☐ Often

I have transportation
☐ No ☐ I take the bus ☐ Yes

About you and your family

I have a High School diploma
☐ No ☐ I am a student ☐ Yes

My income comes from:
☐ I have no income ☐ Subsidies (TANF) ☐ Employment

I know how to use discipline in a positive way
☐ No ☐ I think so ☐ Yes

I spend time for myself going to school, reading, or going to training
☐ Not often ☐ Sometimes ☐ Often

I spend time reading, talking, and/or singing to my child
☐ Not often ☐ Sometimes ☐ Often

I am actively teaching my child to be school ready
☐ No ☐ I think so ☐ Yes

I am actively seeking a kindergarten class for my child
☐ No ☐ Somewhat ☐ Yes

I know my child's rights concerning school
☐ No ☐ I think so ☐ Yes

When I am stressed, I have someone to talk to
☐ Rarely ☐ Sometimes ☐ Most of the time

I am involved in a group, such as PTA, church, volunteering, book club, etc.
☐ No ☐ Sometimes ☐ I'm very involved

Family Name: _____ Site: _____

ChildPlus ID: _____ Date: _____

Getting to know your family

Introduction

We are here to assist you with information, resources, referrals, and opportunities for training. Please let us know how we can support you.

Do you have an emergency?

Do you have any emergency, an immediate need, or need help right now?

- ☐ Food
- ☐ Shelter
- ☐ My Safety
- ☐ Clothing
- ☐ Counseling
- ☐ My child's safety
- ☐ Utility Assistance
- ☐ Health Concerns
- ☐ Alcohol/Drug Abuse
- ☐ Other: _____

Are you interested in a workshop or activity?

We have FREE Workshops for families. Check any that you are interested in.

- ☐ Children with Disabilities
- ☐ Challenging Behaviors
- ☐ Oral Health
- ☐ Job Search
- ☐ No Bullying
- ☐ Apprentice Program
- ☐ Adult Education/College
- ☐ Modeling Positive Behavior
- ☐ Family Literacy for Parents
- ☐ Parenting
- ☐ Health
- ☐ Healthy Eating
- ☐ Money Matters
- ☐ Footsteps2Brilliance literacy app
- ☐ Kindergarten Transition
- ☐ On line HS Diploma
- ☐ Parents as Advocates
- ☐ School Readiness
- ☐ Asthma

Are you interested in Community Services?

Would you like more information on any of these services?

- ☐ Low income housing
- ☐ Mental Health services
- ☐ Food Stamps
- ☐ Legal support
- ☐ Food Pantry
- ☐ Child support
- ☐ Utility Assistance
- ☐ Disability benefits
- ☐ TANF/CalWORKs
- ☐ Foster Care
- ☐ 211 Information hotline
- ☐ Employment resources
- ☐ Unemployment benefits
- ☐ WIC food subsidy
- ☐ English Second Language
- ☐ Clothing sources

Continued on next page

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

APPLICANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

(AGENCY OR INDIVIDUAL FROM WHOM INFORMATION IS REQUESTED)

To: Transitional Assistance Department (TAD)

1. _____, RESIDING AT _____

_____, HEREBY AUTHORIZE YOU TO RELEASE TO THE

Preschool Services Department (PSD)
(NAME OF AGENCY, INSTITUTION, INDIVIDUAL PROVIDER)

SPECIFIC INFORMATION REQUESTED BY THIS AGENCY WHICH I CANNOT PROVIDE CONCERNING program eligibility, including household composition, immunization records, and activity enrollment/participation.

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE Home Visiting Program (HVP) referral and enrollment.

THIS FORM WAS COMPLETED IN ITS ENTIRETY AND WAS READ BY ME (OR READ TO ME) PRIOR TO SIGNING.

SIGNATURE OF APPLICANT		DATE
BIRTHPLACE	BIRTHDATE	MAIDEN NAME OF MOTHER
SIGNATURE OR NAME OF SPOUSE		DATE
BIRTHPLACE OF SPOUSE	BIRTHDATE OF SPOUSE	MAIDEN NAME OF SPOUSE'S MOTHER

SAN BERNARDINO COUNTY Human Services

COMPLAINT AND GRIEVANCE PROCEDURE

INSTRUCTIONS: THE CUSTOMER IS TO READ AND RECEIVE THE TOP PORTION OF THIS FORM. THE BOTTOM PORTION OF THE FORM IS TO BE SIGNED BY SERVICE RECIPIENT AND PLACED IN THE CONTRACTOR'S RECORDS.

If you believe you have been discriminated against, or that there has been a violation of any laws or regulations, or if you have a problem regarding services received, you have the right to file a complaint or tell us your grievance.

The following procedures are to be followed when filing a complaint or grievance.

STEP ONE:
Write down your complaint or grievance and talk to the service provider. Keep a copy for yourself and write down the date you talked to the service provider.

- If answered or resolved at this step, nothing further is required.
- If no answer or resolution within 10 calendar days, proceed with Step Two.

STEP TWO:
Send a copy of your written complaint or grievance, or discuss the complaint or grievance with your County Caseworker. Write down the date you spoke to your Caseworker or send the complaint and keep it with your copy.

- If answered or resolved at this step, nothing further is required.
- If no answer or resolution within 10 calendar days, proceed with Step Three.

STEP THREE:
Send a copy of your written complaint or grievance to the Program Specialist. If you would like a response, include your name, address and telephone number. Your personal information and your complaint and grievance details will be kept confidential.

HS Program Development Division, Contracts Support Unit
ATTN: Program Specialist
825 E. Hospitality Lane, 2nd Floor
San Bernardino, CA 92415-0079

- If answered or resolved at this step, nothing further is required.
- If no answer or resolution within 10 calendar days, proceed with Step Four.

STEP FOUR:
Send a copy of your written complaint or grievance to the Contract Analyst at:

HS Administrative Support Division, ATTN: Contracts Unit
150 S. Lena Road
San Bernardino, CA 92415-0515

You will be contacted within 10 calendar days if you have provided contact information.

Please note: Each of these steps must be completed in the sequence shown.

..... Detach here .....

COMPLAINT AND GRIEVANCE PROCEDURE CERTIFICATION

This certifies I have read, understood, and received the Complaint and Grievance Procedures.

Client Signature _____ Date _____

COUNTY OF SAN BERNARDINO
PRESCHOOL SERVICES DEPARTMENT

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(I/We), the undersigned, parent(s) of _____, a minor, do
Child's Name

hereby authorize _____ as agent(s) for the undersigned to
School Name

consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under, the general or special supervision of any physician and surgeon licensed under the provisions of the Medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment of hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but none of the above treatment will be withheld if the undersigned cannot be reached.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California

I hereby authorize any hospital, which has provided treatment to the above named minor pursuant to the provisions of section 25.8 of the Civil Code of California to surrender physical custody of such minor to the above-named agent upon the completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California.

This authorization shall remain in effect from _____ to _____, unless sooner revoked in writing delivered to said agent(s).

_____ _____
Parent/Guardian Signature Date

_____ _____
Staff Signature/Title Date

_____ _____
Supervisor Signature/Title Date

Child's Birthdate: _____ Date of Last Tetanus: _____

List any medical restrictions: _____

List any known allergies: _____

County of San Bernardino
PRESCHOOL SERVICES DEPARTMENT
EMERGENCY INFORMATION SHEET _____ Walker _____ Bus

1. Child's Last Name:	2. Child's First Name:
3. DOB:	4.Parent/Guardian:
5.Home phone number:	Alternate Phone number:
6. Current E-mail address	
7. Current Mailing Address:	8. Zip Code:

9. PERSON (S) AUTHORIZED TO PICK UP CHILD OR TO CALL IN EMERGENCY:
(18 years or older, photo I.D. will be required)

Name/Relationship to Child:	Home Phone:
Address:	Work Phone:
Name/Relationship to Child:	Home Phone:
Address:	Work Phone:
Name/Relationship to Child:	Home Phone:
Address:	Work Phone:

MEDICAL INFORMATION		DENTAL INFORMATION	
10. Medical insurance provider		17. Dental insurance provider	
11. Medical record/ insurance number		18. Dental insurance number	
12. Doctor's Name / Group		19. Dentist's Name / Group	
13. Doctor's Address		20. Dentist's Address	
14. Doctor's Phone number		21. Dentist's Phone number	
15. Date of last visit		22. Date of last visit	
16. Preferred Hospital		23. Allergies	

24. Instructions for emergency (In case Parent/Guardian or Doctor cannot be reached): Please Initial

_____ Call Paramedics/Transport to the nearest Hospital or Emergency Facility

_____ I understand that if I cannot supply telephone numbers of three persons authorized to pick up my child, in the event of an emergency, **Preschool Services Department will contact the Local Law Enforcement Agency to assume custody.**

25. Bus Stop (Pick-up):	26. Bus Stop (Drop-off):
27. Pick-up time:	28. Drop-off time:

29. Special instructions:

_____ _____

Parent/Guardian Signature Date

HVP ENROLLMENT APPLICATION

Parent/guardian's First Name	Middle Initial	Last	Parent/guardian DOB (mm/dd/yyyy)

Education level	Employed? N/A P/T F/T	School/Training? N/A P/T F/T

Latino ☐ Yes ☐ No Race _____	Primary Language	Secondary Language

1 Child's Name	Latino? Yes ☐ No ☐ Race	Child's DOB	Primary Language	Secondary Language
2 Second Child's Name	Latino? Yes ☐ No ☐ Race	Child's DOB	Primary Language	Secondary Language

Residential Address			Mailing Address (if different from Residential Address)		
City	State CA	Zip Code	City	State	Zip Code

Primary Phone Number (including area code) Home ☐ Cell ☐	Other Phone (including area code) Home ☐ Work ☐ Cell ☐ Message ☐

Total in Family _____	Ok to text? YES ☐ NO ☐	Ok to email? YES ☐ NO ☐	Email Address:

Current Housing: ☐Rent ☐Own ☐ Homeless

ELIGIBILITY INFORMATION

Family Receives: SSI YES ☐ NO ☐ TANF/CalWORKs YES ☐ NO ☐	Check one if applicable: ☐Medi-Cal ☐IEHP ☐Healthy Families ☐Emergency ☐ Other	Does Family Have Medical Insurance? ☐Yes ☐No

Does family receive WIC? ☐Yes ☐No	Does Family Receive CalFRESH (EBT)? ☐Yes ☐No	Does Child Have Dental Insurance? ☐Yes ☐No

PRENATAL INFORMATION

☐ N/A ☐ Pregnant before Enrollment ☐ First Pregnancy Expected delivery date: _____

Your disclosure of this information is strictly voluntary.

1. Does your child have a disability? _____ (If no, please go to question #6)
2. Type of special need or disability _____
3. Has the disability been professionally diagnosed? (If yes, at what age _____? By whom? _____
4. Does the child have an IFSP/IEP? _____
5. Is the child receiving special services for the disability? _____
6. In your opinion, does your child have a special need that has not yet been diagnosed? If yes, please explain:

Applicant Signature : _____ **Date:** _____

Certification: I certify that this information is true. If any part is false, my participation in this agency's program may be terminated. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

COUNTY USE ONLY

HVP Start Date	TAD Office:	C-IV ID:	ChildPlus Individual ID: ChildPlus Family ID:

Staff Signature: **Print Name** **Date:**