ENTERPRISE ELEMENTARY SCHOOL DISTRICT
PRESCHOOL PROGRAM

Thank you for your interest in enrolling in the Enterprise Preschool program.
We serve families with children ages 3-5 years old.
Children must be 3 years old by December 1st of current school year

To determine eligibility call the EESD preschool office to set up and appointment.
Please complete paperwork contained in this application before your appointment.
Drop off applications will not be accepted.

Children must be able to use toilet independently.

- **1 months' worth of current pay stubs for anyone who is working in the home** ***(must be within the last 30 days)***
- **Proof of any other form of Income you are receiving** ***(Cash Aid, SSI, etc.)***
- **Proof of Residency** ***(utility bill, rental agreement)***
- **Evidence of any absent birth parent not living in the home**
- **Any court or important documents affecting the life of the child**
- **Birth Certificates or record for ALL children living in the home**
- **Updated Immunization records for the child you are enrolling**
- **Physician's Report signed and dated by the Physician within the past year** ***(If a doctor's appointment is scheduled an appointment card is acceptable at time of enrollment)***

Empowering Every Child, Everyday, To Create a Better World.

Alta Mesa	Boulder Creek	Rother
2301 Saturn Skyway	505 Springer Dr.	795 Hartnell Ave.
Am: 8:00-11:00	Am: 7:30-10:30	Am: 7:30-10:30
Pm: 11:30-2:30	Pm: 11:00-2:00	Pm: 11:30-2:30

Preschool Office
795 Hartnell Ave.
PHONE: (530)224-4178 EMAIL: nbobier@eesd.net

ENTERPRISE ELEMENTARY SCHOOL DISTRICT

1155 Mistletoe Lane, Redding, CA 96002 • Phone: (530) 224-4100 • FAX: (530) 224-4101 • www.eesd.net

Empowering every child, every day to create a better world

Dear Parents,

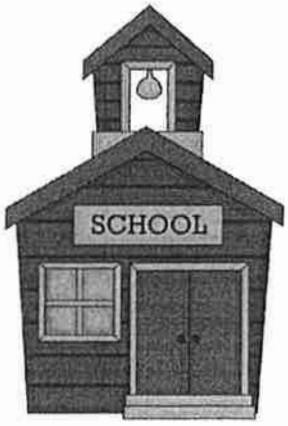
We are EXCITED that you are interested in the Enterprise Elementary School District's preschool program! We look forward to working with you as parents to help ensure that your child has an awesome start in school. The California State Preschool Program (CSPP)at Enterprise is a curriculum based preschool program for children ages 3 to 4 years old.

The objective of Enterprise Preschool Program

Our goal is to successfully establish a rich, educational environment that will enable all children to learn and thrive. We accomplish this in part by utilizing *Little Treasures Pre-K* Program and *California Preschool Curriculum Framework*. These programs address the cognitive, language, social-emotional, and physical development of each child. Additionally, your child's growth and development are assessed twice a year using the Desired Results Developmental Profile (DRDP) and the READY! for Kindergarten assessment. Our teachers also regularly adjust the curriculum, based on their observations and assessments of the children, as well as their interests.

How can you help ensure your child's success in preschool?

- Make sure your child is well rested each day and ready to learn.
- Arrive at school on time to maximize learning and minimize disruptions to the class.
- Encourage problem solving.
- Read together every day, be interactive, and engage your child so he/she will actively listen to a story.
- Encourage children to discuss their day at school
- Resist doing for children what they can do themselves.



It is our goal at Enterprise to work in partnership with you to ensure your child is prepared for success in school. If you have any questions, call our preschool office at 530-224-4178.

Sincerely,

Heather A Armelino

Heather Armelino, Preschool Director
530-224-4100

Preschool Emergency Information/Health Card

○Alta Mesa ○Boulder Creek ○Rother

Student's LEGAL Name _____ Date of Birth _____ Gender: M F *(circle one)*
(from birth certificate) *Last Name* *First Name* *Middle Name* *Month/Day/Year*

Home Phone _____ Social Security #: _____ Teacher/Grade: _____

It is the parent's responsibility to notify the school of any changes in the Emergency Contact Information.

PARENTS and/or GUARDIANS Child lives with: ○Father ○Mother ○Other _____

Parent/Guardian Name _____	***Parent/Guardian Name*** _____
Relationship _____	Relationship _____
Social Security # _____	Social Security # _____
Birth Date _____	Birth Date _____
Address _____ *Address City Zip*	Address _____ *Address City Zip*
Place of Employment _____	Place of Employment _____
Work/Cell Phone _____	Work/Cell Phone _____
Email Address _____	Email Address _____

If the parent cannot be reached, permission is given to release the student to the person's listed below. Additional names may be added to the back of this form.

Person(s) to call in an emergency if parent/guardian is not available:

Name _____	Name _____	Name _____
Relationship _____	Relationship _____	Relationship _____
Home Phone _____	Home Phone _____	Home Phone _____
Work/Cell Phone _____	Work/Cell Phone _____	Work/Cell Phone _____

List all brothers and sisters under age 18:

Name	M/F	Birth Date	School

Health Conditions: ○Asthma* ○Epilepsy* ○Diabetes* ○Heart Condition* ○Seizures* ○Allergy, foods (*if this is checked, please fill out ESD Form A*) ○Allergy, other* ○Operation, serious injury or illness* ○Other*

***Explain** _____

Yes No

○ ○ Does your child take medication regularly? *If so, what kind?* _____
○ ○ Does your child have a speech problem? *Explain* _____
○ ○ Does your child have an ear problem? *If so, what kind?* _____
○ ○ Does your child have a physical handicap? *Explain* _____
○ ○ Does your child have an eye problem? *Need glasses?* _____

We will ALWAYS try to contact parents and the above listed names before a student will be transported for emergency medical treatment

PLEASE CHECK WITH BOX AND SIGN BELOW:

○ I *do not* wish medical care secured for my child because of religious/personal beliefs. Please explain.
○ I hereby authorize the staff of Enterprise Elementary School District to secure and sign for emergency medical care for my child at my expense, when necessary.

***I hereby give my consent to release relevant health information, pertaining to my child, to school personnel who will be providing educational and safety services for my child during school and school related activities.**

_____
Parent/Guardian Signature *Date*

Enterprise Elementary School District Preschool Registration

795 Hartnell Ave, Redding, CA 96002 Phone: 530-224-4178

☐Alta Mesa ☐ Boulder Creek ☐ Rother

Student's LEGAL Name _____ Date of Birth _____ Gender: M F *(circle one)*
(from birth certificate) *Last Name* *First Name* *Middle Name* *Month/Day/Year*

Social Security # _____ Home Phone: _____

Residence Address _____
Address *City* *State* *Zip*

Mailing Address _____
(If different from above) *Address* *City* *State* *Zip*

Mother/Guardian _____ Father/Guardian _____
Last Name *First Name* *Last Name* *First Name*

Student's Birthplace: _____ If not born in the U.S., what month/year did your child enter U.S. _____
City/State/County *Month/Year*

ETHNICITY: ***Mark the ethnicity with which the student most closely identifies: Please check one:***

- O Hispanic/Latino -- A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race
- O Not Hispanic or Latino

RACE: (Please check up to five racial categories) The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be.

OAmerican Indian of Alaskan Native (100)
(Person having origins in any of the original people of North and South America (including Central America)

OChinese (201)
OJapanese (202)
OKorean (203)
OVietnamese (204)
OAsian Indian (205)
OLaotian (206)
OCambodian (207)
OHmong (208)
OOther Asian (299)
OHawaiian (301)
OGuamanian (302)
OSamoan (303)
OTahitian (304)
OOther Pacific Islander (399)
OAfrican American or Black (600)
OWhite (700)
(Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East)

PARENT EDUCATION LEVEL: Check the response that describes the highest education level of the parent/guardian(s):

ONot a High School Graduate
OHigh School Graduate
OSome College (includes AA)
OCollege Graduate
OGraduate School/Post Grad Training
ODeclined to State

LEGAL ALERT: Do you have a restraining order which prevents someone from picking up your child? OYes ONo

If YES, please provide a copy of the restraining order & list the name. _____
Name *Relationship* *Legal Document*

_____ _____
Parent/Guardian Signature *Date*

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

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

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS NUMBER STREET	CITY	STATE ZIP		BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE ZIP		HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE ZIP		HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE | DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION | DATE LEFT

ENTERPRISE ELEMENTARY SCHOOL DISTRICT

HOME LANGUAGE SURVEY

The California Education Code requires schools to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students. **If the Home Language Survey (HLS) indicates that your child has spoken or speaks a language other than English, your child will be assessed to determine his/her fluency level in English.** If your child is tested, you will be notified of the results along with a recommended program of instruction. Your cooperation in helping us meet this important requirement is requested.

Please answer the following questions:

NAME OF STUDENT _____ _____ _____
Last *First* *Middle* *Grade* *Age*

1. Which language did your son or daughter learn when he or she first began to talk?

   _____

2. What language does your son or daughter most frequently use at home?

   _____

3. What language do you use most frequently to speak to your son or daughter?

   _____

4. Name the language most often spoken by the adults at home?

   _____

<u>If a language **OTHER THAN ENGLISH** is indicated on any line above, please complete the following:</u>

5. Does your child:
   a) <u>Understand</u> ❑ Yes ❑ No; b) <u>Speak</u> ❑ Yes ❑ No; c) <u>Read</u> ❑ Yes ❑ No; OR
   d) <u>Write</u> ❑ Yes ❑ No in this language?

6. Has your child received formal INSTRUCTION (attended school) in a <u>language other than English?</u>
   ❑ Yes ❑ No If YES, Where_____ Dates _____

7. Did your child attend school in another country? ❑ Yes ❑ No IF YES, please provide us with name and address of the school:
   School _____ Address_____

8. If your child was born in another country, what MONTH/DAY/YEAR did your family move to the United States? _____

9. **On what date did your child first enroll in a United States school?** _____
   Grade level first enrolled: _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

Revised 12/8/16

CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ _____
DATE PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER 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'S 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'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, 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'S SIGNATURE	DATE

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 not limited to, the following:

(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 provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

Community Care Licensing

ADDRESS

520 Cohasset Rd. Suite 6

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Chico , Ca	95926	(530)895-5033

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

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

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Department of Social Services Community Care Licensing

   Licensing Office Address: 520 Cohasset Road, Suite 6 Chico, CA 95926

   Licensing Office Telephone #: (530)895-5033

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.

8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: ***CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.***

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995 (9/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

_____
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

NOTE: ***This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.***

For the Department of Justice "Registered Sex Offender"database go to www.meganslaw.ca.gov

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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

ENTERPRISE ELEMENTARY SCHOOL DISTRICT

1155 Mistletoe Lane, Redding, CA 96002 ▪ Phone: (530) 224-4100 ▪ FAX: (530) 224-4101 ▪ www.eesd.net

Empowering every child, every day to create a better world

Dear Parent or Guardian

In the event that your child has a special meal request due to allergies or chronic disease or disability, please take this Medical Statement form to a recognized medical authority to be filled out. The completed form will then be stored in your child's cumulative files. A copy of the completed form will be stored in the District Nurse's files and in cafeteria files as well. Please allow five working days before the special request can be processed.

Due to our Child Nutrition Program regulations, we must have current specific information to best serve your child's special meal needs. Of note, if a food is restricted from the child's diet, we need a suggested substitute food from the recognized medical authority. A completed form must be on file each school year in order for us to serve a special meal or make substitutions.

We can fax this form as well as a menu that can be modified to the medical authority of your choice. Please contact me or the District Nurse at 530-224-4100 if you have further questions.

Sincerely,

Cindy Ksiazek
Food Service Director

This institution is an equal opportunity provider.

MEDICAL STATEMENT FOR PARTICIPANTS WITH FOOD ALLERGIES

Other medical personnel may complete this form (dietician, speech pathologist, and occupational therapist), but a physician or other recognized medical authority must sign in agreement as to what is written. For the purposes of this program, a "recognized medical authority" means a licensed physician, nurse, or physician's assistant.

School Site _____ School Phone _____ School Fax _____ School Contact Person _____

Student Name _____ Parents _____

Student Birthdate _____ Age _____ Address _____

Grade/Teacher _____ Parent Phone #/s _____

Does the student have a disability? ◯ Yes ◯ No
If yes, describe the major life activities affected by the disability.

If Yes, does the student have special nutritional or feeding needs? *If Yes, complete this form and have it signed by a physician.* ◯ Yes ◯ No

If the student is not disabled, does he/she have special nutritional or feeding needs? ◯ Yes ◯ No
If Yes, complete this form and have it signed by the appropriate medical authority.

List or attach any dietary restriction, special diet, food intolerance, and/or allergies.

List or attach any substitution foods recommended.

List any special equipment or utensils needed.

Indicate any other comments regarding the student's eating or feeding patterns and requirements.

Parent Signature _____ Date _____

Physician/Medical Authority Signature _____ Date _____ Physician Name (please print) _____

We will fax or mail school meal menus to the appropriate medical authority for modification if necessary. Please call the district nurse at 224-4100 or Fax 530-224-4101 (ATTN: Nurse) to request that service.

COPIES:

Nurse Office _____	School File _____	Nutrition Office _____
ACE Office _____	Transportation _____	Kitchen _____

12/2017 - lm