



Central Unified School District  
 Special Education & Support Services Department  
**INCLUSION PRESCHOOL PROGRAM**  
**PEER MODEL APPLICATION FORM**  
**2018-2019**

**REQUIREMENTS to be attached with application (only complete applications accepted):**

1. Proof of residency within the Central Unified School District (copy of PG&E statement; rental agreement; or escrow statement).
2. Birth Certificate (copy acceptable)
3. Immunization Card (copy acceptable)

**TIMELINES**

Applications may be turned in between March 7 – April 27, 2018. Applications can be faxed to (559) 271-7211, dropped off in person in room #12 at the Central Unified District Office or mailed to: Central Unified School District; Special Education Department; 4605 N. Polk; Fresno, CA 93722.

**PART I. FAMILY INFORMATION**

Child's Last Name:		First Name:		M:	
Child's Birth Date:		Child's Ethnicity:		Languages spoken in home:	
Parent 1 Name:					
Parent 1 Address:					
Parent 1 Phone #		E-Mail Address:			
Parent 2 Name:					
Parent 2 Address:					
Parent 2 Phone #		E-Mail Address:			

**PART II OTHER HOUSEHOLD MEMBERS:**

Name:		Age:		M/F	
Name:		Age:		M/F	
Name:		Age:		M/F	
Name:		Age:		M/F	
Name:		Age:		M/F	
Name:		Age:		M/F	

**PART III. HEALTH & IMMUNIZATION:** A copy of the following is required prior to admission into preschool (unless contrary to religious beliefs or medical condition).

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Polio – 3 doses</li> <li><input checked="" type="checkbox"/> DPT/DTAP/DTP – 4 doses</li> <li><input checked="" type="checkbox"/> MMR – 1 dose after the first birthday</li> <li><input checked="" type="checkbox"/> PPD / TB Test – A negative test given after 2/1/2017 or proof of a negative chest x-ray. If a positive test result was found, with a clearance of tuberculosis from your Health care provider. Students with exemptions will be excluded from school if an outbreak occurs.</li> </ul> | <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Hepatitis B – 3 doses</li> <li><input checked="" type="checkbox"/> Varicella – 1 dose</li> <li><input checked="" type="checkbox"/> HIB – at least 1 dose on or after the first birthday</li> </ul> |
|---|---|

**PART IV. HEALTH HISTORY** (please briefly describe yes answers)

1. Please explain any health problems, special considerations or limitations your child has (medical, physical, developmental delays, allergies, etc.): \_\_\_\_\_
2. Does your child take any medication? Yes  No  \_\_\_\_\_
3. Is your child toilet trained during the day? Yes  No  \_\_\_\_\_
4. Does your child have any medical treatments? Yes  No  \_\_\_\_\_
5. Do you have any concerns about your child's vision? Yes  No  \_\_\_\_\_
6. Do you have any concerns about your child's hearing? Yes  No  \_\_\_\_\_
7. Has your child had frequent ear infections or ear tubes? Yes  No  \_\_\_\_\_
8. Who is your child's primary care doctor or Pediatrician? \_\_\_\_\_
9. Has your child ever received an evaluation or assessment (medical, neurological, psychological, educational)?  
Yes  No  \_\_\_\_\_

**PART V. BIRTH HISTORY** (please briefly describe yes answers)

1. Was your child born full term or prematurely? \_\_\_\_\_ Birth Weight? \_\_\_\_\_
2. Is your child a twin? Yes  No  Or adopted? Yes  No  Or in foster care? Yes  No
3. Did mother use medication during pregnancy? Yes  No  \_\_\_\_\_
4. Did mother use alcohol or drugs during pregnancy? Yes  No  \_\_\_\_\_
5. Did mother smoke during pregnancy? Yes  No  \_\_\_\_\_
6. Did mother have health problems at birth or in their first six months? Yes  No  \_\_\_\_\_

**PART VI. MILESTONES** (please briefly describe yes answers)

At what age did your child sit up? \_\_\_\_\_ crawl? \_\_\_\_\_ walk? \_\_\_\_\_  
talk? \_\_\_\_\_ toilet trained? \_\_\_\_\_  
Has the child had group play experience? Yes  No  if yes describe: \_\_\_\_\_  
Has your child been in preschool or a daycare setting before? Yes  No  Name: \_\_\_\_\_  
Is your child currently on a waiting list for preschool? Yes  No  Name: \_\_\_\_\_ Date Applied? \_\_\_\_\_  
Is the student currently being serviced by an Individual Education Plan (IEP)? Yes  No   
Provided by? \_\_\_\_\_ Where? \_\_\_\_\_  
Parents brief evaluation of child's personality: \_\_\_\_\_

Why do you believe your child will be a good fit for the inclusion preschool program? \_\_\_\_\_

How did you hear about our program? \_\_\_\_\_

Family Income (check one): under \$25,000  \$25,001- \$45,999  \$46,000 and above

**PART VII. Class Placement Preference**

My child is available for an AM or PM placement, however I prefer \_\_\_\_\_.

**PART VIII. Certification:** I certify that to the best of my knowledge the above statements are true...

Signature of Parent(s): \_\_\_\_\_ Date: \_\_\_\_\_

**PART VIII. AUTHORIZED OFFICE USE ONLY** (check appropriate boxes)

◇ Eligibility Status: Accepted  Waiting List  ◇ First day of enrollment: \_\_\_\_\_ ◇ a.m.  p.m.   
◇ Placement: 3 Year Old Class AM  PM ; 4 Year Old Class AM  PM   
◇ Signature of Authorized Representative: \_\_\_\_\_ Title: \_\_\_\_\_