



OFFICE OF EQUITY, ACCESS,
COLLEGE & CAREER READINESS
Volunteers in Public Schools



Date submitted to site: _____
 Date submitted to District VIPS Office: _____
 Current VIPS: Yes No - School: _____
 Current District employee Yes E 00 _____



VIPS APPLICATION-PRESCHOOL
APPLICATIONS ARE REQUIRED EVERY 4 YEARS

QUESTIONS CONCERNING APPLICATION SHOULD BE DIRECTED TO THE SITE VIPS COORDINATOR

Contact Information (PLEASE PRINT)

Name _____ () _____
 Last First M. I. Phone #

Home Address _____
 Street Apt. City Zip Code

Date of Birth: _____ E-mail: _____

Government-Issued **Unexpired** Photo ID _____ (Please attach a copy of your photo ID, e.g. California Driver's License, California ID, Military ID, Passport or International ID. **Picture must be clear**)

School: _____

Child's Name: _____ Grade: _____ Teacher: _____

Child's Name: _____ Grade: _____ Teacher: _____

Child's Name: _____ Grade: _____ Teacher: _____

Personal Information

Have you ever had the **disease tuberculosis**? (**Nota TB Test**) Yes No If answer is "yes," when? _____

Have you ever had a **positive** skin test (PPD) Yes No If answer is "yes," when? _____

**PLEASE ATTACH A COPY OF TB TEST RESULTS OR TB RISK ASSESSMENT QUESTIONNAIRE
 CERTIFICATE OF COMPLETION TO APPLICATION—
 MUST SHOW DATE GIVEN, DATE READ, RESULTS AND THE NAME OF MEDICAL FACILITY**

Can you perform the work of the position with or without accommodation? Yes No

In case of an emergency, please notify: _____ Phone # () _____

Senate Bill No. 792 – California Daycare Immunization Requirements for Adults

As of September 1, 2016, all staff and volunteers working with preschool aged children must have proof of a measles and pertussis vaccination, also known as whooping cough vaccination, or proof of immunity from a medical professional. For the influenza vaccine, commonly known as the flu shot, all staff and volunteers must receive this vaccination between August 1 and December or complete a refusal declaration each year. Proof of Tuberculosis (TB skin test) clearance is required.

Measles:

Date vaccination was administered _____
 Tests on _____ indicate current immunity to disease

Pertussis:

Date vaccination was administered _____

Influenza:

Date vaccination was administered _____
 Declined immunization

If declining an influenza vaccination please write a statement:

Tuberculosis:

Date TB test was given: _____
 Date TB test was read: _____
 Positive Negative
 X-ray required (if positive result)
 X-ray date: _____
 Positive Negative
 Risk Assessment Date: _____

Patient is exempt from the requirements of this section due to a physical condition or medical circumstances where immunization is not safe

Name of Physician & Physician Stamp	Telephone Number	Physician Signature
	Date:	

Application continues on next page. Please read and complete all pages.

HEALTH SCREENING REPORT - FACILITY PERSONNEL

All personnel, including applicant, licensee or employed staff of Residential Care Facilities for the Elderly, Community Care or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.

A health screening, by or under the direction of a physician must have been performed not more than one year prior to employment or within seven (7) days after employment.

FACILITY NAME
FACILITY ADDRESS

PERSON'S NAME	AGE		
POSITION TITLE	TYPE OF FACILITY	WORK DAYS PER WEEK	WORK HOURS PER DAY
DUTY STATEMENT			

TYPES OF PERSONS SERVED (Check appropriate items)

- Infants Adults Developmentally Disabled Physically Handicapped
 Children Elderly Mentally Disordered Drug/Alcohol Addiction
 Other (specify) _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT.

SIGNATURE OF APPLICANT/LICENSEE OR EMPLOYEE	ADDRESS	DATE
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NOTE TO PHYSICIAN: Personnel in Residential Care Facilities for the Elderly, Community Care or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above named person.

EVALUATION OF GENERAL HEALTH

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONNEL

DATE OF T.B. TEST	<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE	ACTION TAKEN (IF POSITIVE)
DATE OF HEALTH SCREENING	NAME OF PHYSICIAN (PHYSICIAN'S STAMP)	DATE
HEALTH SCREENING BY: (ORIGINAL SIGNATURE)	TELEPHONE #	DATE

**LONG BEACH UNIFIED SCHOOL DISTRICT
REPORT OF CONVICTIONS AND FINGERPRINTING FOR VOLUNTEERS**

ALL VOLUNTEERS WHO WILL PROVIDE SERVICES TO THE DISTRICT AND HAVE DIRECT INTERACTION WITH STUDENTS WITHOUT THE DIRECT SUPERVISION OF A CREDENTIALLED EMPLOYEE MUST BE FINGERPRINTED.

Please answer both questions below. Social security number is required only when reporting a conviction.

PRINT NAME (LAST, FIRST AND MIDDLE)	SOCIAL SECURITY NUMBER
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The District appreciates your interest in serving its students and schools in a volunteer capacity. In order to protect its students, please note that, prior to your being considered for volunteer services, the District may require potential volunteers who have prior convictions to provide a certified copy of all relevant records including, but not limited to, conviction reports, probation reports, and other related court records. A conviction does not necessarily disqualify you from volunteering.

FAILURE TO ITEMIZE ALL CONVICTIONS IS CAUSE FOR YOUR DISQUALIFICATION. IF YOU DO NOT FULLY DISCLOSE SUCH INFORMATION ON THIS FORM NOW, IT IS CAUSE FOR REJECTION FROM VOLUNTEER SERVICES.

PLEASE READ THE FOLLOWING NOTES CAREFULLY:

Please list below any and all convictions, including misdemeanors and/or felonies, you received at any time during your lifetime. The term “conviction” includes a plea or verdict of guilty or finding of guilt by a court in a trial without a jury, or a conviction following a plea of nolo contendere. If you have been convicted of any criminal offense, please specify and explain all convictions on this form. You must report all convictions for sex and/or drug offenses specified in Education Code sections 44010 and 44011 and any convictions for serious or violent felonies specified in Penal Code sections 667.5 and 1192.7. Any convictions set aside pursuant to Penal Code section 1203.4 must be disclosed, as such convictions are by law convictions for the purpose of this question (see Education Code section 44009). A conviction will not necessarily result in automatic disqualification. You are solely responsible for making the determination of whether a conviction must be disclosed. District staff cannot and will not assist you. Failure to report an otherwise reportable conviction will not be excused by your misunderstanding of the law.

HAVE YOU, AS A JUVENILE OR ADULT, EVER BEEN CONVICTED, FINED, IMPRISONED, PLACED ON PROBATION, OR SENTENCED, IN ANY CIVIL, CRIMINAL, OR MILITARY COURT, OR HAVE YOU EVER FORFEITED BAIL? NO YES

Name of Offense (Explain in detail on back of this form. Use additional pages if necessary.)	Offense Code #	Date Mo/Yr	Location (City & State)	Misdemeanor or Felony?	If Imprisoned, how long?	If Fined \$ Amount	If Probation From--- To----

HAS YOUR DRIVER’S LICENSE EVER BEEN SUSPENDED OR REVOKED? NO YES
If YES, explain, including when, where it occurred, the outcome, AND attach H6 DMV report

EXPLANATION OF CONVICTION:

Please use the next page to write about the offense(s) for which you were convicted. Explain in detail, the incident(s) and the surrounding circumstances, outcome, etc. Make sure the information you provide matches the convictions on this form.

EXPLANATION OF EVENTS: (You may attach other pages, if necessary):

PLEASE READ BELOW BEFORE SIGNING:

I declare that I have read and understand all of the questions and statements listed on all pages of this Report of Convictions form and the answers I have given are true, correct, and complete. I understand it is my responsibility to list any and all convictions, and that anything I may have forgotten or failed to list will result in rejection as a volunteer. I have listed all of my convictions.

I understand that it is district policy for me to wear my VIPS badge at all times when I am on campus. The badge is the property of LBUSD, and it should be kept on site at all times. I agree not to take the badge home nor loan it to others. I agree to sign in and out each time I am on campus as a volunteer. I agree to keep confidential information about students' academic and behavioral performance in the classroom(s) where I volunteer my time.

SIGNATURE OF APPLICANT

DATE SIGNED

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FOR SCHOOL USE ONLY:
KEEP COPY OF ALL DOCUMENTS ON FILE

Application reviewed by site VIPS coordinator: _____ Date: _____

Application checked for completeness and accuracy . Proof of TB test and current Photo ID are attached.

Principal signature: _____ Date: _____

School: _____