

Kindergarten and Transitional Kindergarten 2014-15 Registration Packet Checklist

Indicate for which program(s) you are registering your child:

☐ **Regular Kindergarten**

Eligibility for Enrollment:

- Must be born on or before September 1, 2009

☐ **Transitional Kindergarten**

Eligibility for Enrollment:

- Must be born between September 2, 2009 and December 2, 2009

Indicate which school site and session in order of preference. Your first choice would be numbered with a "1". *(Note: your preference is not a guarantee of placement.)*

- _____ Antelope Creek - morning session (for office use) AC, CS, PW, RE, SE, VV
- _____ Antelope Creek - afternoon session (for office use) AC, CS, PW, RE, SE, VV
- _____ Rock Creek - morning session (for office use) BR, RC, RU, SR, TO
- _____ Rock Creek - afternoon session (for office use) BR, RC, RU, SR, TO
- _____

Indicate your home school.

- | | | |
|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Antelope Creek | <input type="checkbox"/> Rock Creek | <input type="checkbox"/> Sunset Ranch |
| <input type="checkbox"/> Breen | <input type="checkbox"/> Rocklin | <input type="checkbox"/> Twin Oaks |
| <input type="checkbox"/> Cobblestone | <input type="checkbox"/> Ruhkala | <input type="checkbox"/> Valley View |
| <input type="checkbox"/> Parker Whitney | <input type="checkbox"/> Sierra | |

| ✓ | Documents | |
|---|--------------------------------------|---|
| | Kindergarten Welcome Letter | Parent keeps |
| | District Calendar | Parent keeps |
| | Enrollment Procedures | |
| | Residence Verification | |
| | Student Registration | <i>Note: Parent must provide original birth certificate at time of registration</i> |
| | Home Language Survey | |
| | Emergency Card | |
| | Record of Special Education Programs | |
| | Letter from Health Services | Parent keeps |
| | Health & Developmental Information | |
| | Health Exam | Due to site office no later than 11/15/15 |
| | Proof of Immunization Record ** | Parent provides |
| | Oral health letter | Parent keeps |
| | Oral health form | Due to site office no later than 6/1/15 |

*** California School Immunization Record will be printed at each site. Parents only need to provide the Proof of Immunizations so a copy can be made and included for the site records.*

Rocklin Unified School District

2615 Sierra Meadows Drive • Rocklin, CA 95677

Phone (916) 624-2428 • FAX (916) 624-7246



Roger Stock, Superintendent
Todd Cutler, Deputy Superintendent

Barbara Patterson, Associate Superintendent
Michael S. Garrison, Assistant Superintendent

January 15, 2014

Dear Kindergarten and Transitional Kindergarten Parents:

It is a sincere pleasure to welcome you and your child to our school community. We are excited about having an opportunity to work with you as a full partner in your child's education. Rocklin Unified School District is committed to providing each student with a high quality learning experience. We believe the best way to achieve academic success is through the combined efforts of the school, parents, and child.

Our grade level curriculum is aligned to the California Common Core State Standards. These standards drive the plans for daily instruction and homework; and also provide the basis for progress reports and report cards. Parent/teacher conferences add further clarity regarding student progress. Additionally, we are committed to helping students maintain a natural curiosity and confidence in themselves as learners while developing behaviors that will enable them to become active and focused learners in the classroom. Our teachers are highly skilled professionals who will determine the manner of instruction, motivation, grouping, pacing, reinforcing, and re-teaching in order to meet the needs of each student.

Please become part of our active parental involvement efforts throughout the school. Working together we can do it better. Have a great school year!

Sincerely,

Roger Stock
Superintendent

Rocklin Unified School District
Enrollment Procedures

Welcome to Rocklin Unified School District. As a parent new to our school district, please be aware that our district's enrollment is growing due to ongoing construction of new homes in Rocklin. Consequently, **it is extremely difficult to guarantee that your child will be able to enroll in the school in your neighborhood.** We understand that parents buying a home in Rocklin often do so in order to be in a certain school area. Unfortunately, because of the volume of enrollment and in order to comply with state laws and district policies on class size, your child may not be able to attend the school in your neighborhood.

Procedures for placement of students in our schools:

1. **The registration packet will not be considered officially received by the school until all forms (proof of residence, immunizations, birth certificates, etc.) are completed. Upon completion of all forms, the registration packet will be date and time stamped by school personnel.**
2. **We guarantee that your child will be able to attend a school within the Rocklin Unified School District.**
3. If the classes in your child's grade level are filled in your neighborhood school (school of residence), it will be necessary for the District to transport your child to another school in Rocklin that has room in your child's grade. The District will provide transportation from your neighborhood school to the school to which your child has been redirected.
4. If your child is redirected, he/she will be placed on a waiting list at your neighborhood school and, if an opening occurs, you will be called and offered the opportunity for your child to return to your neighborhood school. Should you decline the position offered midyear, a space at your neighborhood school cannot be guaranteed for the following year.
5. If your neighborhood school only has room for some of your children and your other children must be redirected, you should enroll the child(ren) who can be accepted in your neighborhood school and wait for an opening to return your other child(ren).
6. With an increase of enrollment, there may be overcrowding in some of our classrooms. If this occurs, there is a possibility that your child may be reassigned to a new class during the school year. If your child is affected, you will be notified prior to the move, and the reasons will be explained to you at that time.
7. The District may make multi-grade classes in our schools (i.e. K/1, 1/2, 2/3, etc.). Multi-grade classes are carefully constructed to insure academic success for all students. Students in multi-grade classes have the same educational opportunities as single grade classes.
8. Intradistrict Agreements (going from one school in the district to another, per parent's request), will only be accepted on a space available basis. *No pupil who currently resides in the attendance area of a school shall be displaced by pupils transferring from outside the attendance area. During the first ten days after enrollment, pupils residing within the attendance area of the school shall have precedence over students attending school on an Intradistrict Agreement. **Should an overload occur during the first ten days after enrollment, pupils shall be returned to their school of residence. Should the school of residence be overloaded, said pupils may be transferred to another school.** This agreement may be revoked for violations of district rules and/or school rules related to discipline/ behavior/ attendance. Transportation is the responsibility of the parent/guardian.* (BP/AR 5116.1)

Your signature indicates that you read the enrollment procedures.

Child's Name _____

Parent/Guardian Signature _____

Date _____

ROCKLIN UNIFIED SCHOOL DISTRICT

2615 Sierra Meadows Drive
Rocklin, CA 95677
916-624-2428

RESIDENCE VERIFICATION FORM

State Compliance Requirements:

Education Code Section 48200 states in part, that "Each person subject to compulsory full-time education...shall attend the public full-time school...in which the **residency** of either the parent or legal guardian is located and each parent, guardian, or person having control or charge of such pupil shall send the pupil to the public full-time school...in which the residence of either the parent or legal guardian is located."

☐ Check here if not a district resident.
(If box is checked, **an approved Interdistrict Agreement must be on file.**)

☐ Check here if a district resident.
(If box is checked, *complete the information below.*)

Parent/Guardian must provide one form of residency verification.

Attach a copy and present one of the following in parent(s) or legal guardian(s) name for residence verification:

_____ **Utility Bill**

_____ **Letter from Social Services verifying residency**
(verification must be current – within past 30 days)

_____ **Garbage Bill**

_____ **Home Purchase Agreement/Contract**
(utility bill required within 30 days of move in date)

_____ **Cable Bill**

_____ **Home Telephone Bill**
(cellular phone bills are not acceptable)

I attest that the above information I have provided to the Rocklin Unified School District is true and accurate. I also understand that any changes of address must be reported to the school secretary.

Parent/Guardian Signature: _____ Date: _____

Student Name: _____

Birth Date: _____ Entering Grade: _____

School of Residence: _____

ROCKLIN UNIFIED SCHOOL DISTRICT
STUDENT REGISTRATION FORM

(FOR OFFICE USE ONLY)

ENROLLMENT DATE _____ SCHOOL _____ GRADE _____ TEACHER _____

LAST SCHOOL ATTENDED _____ DATE LAST ATTENDED _____

ADDRESS OF LAST SCHOOL _____

IS STUDENT CURRENTLY EXPELLED OR RECOMMENDED FOR EXPULSION? ☐ YES ☐ NO

HAS STUDENT PREVIOUSLY BEEN ENROLLED IN ROCKLIN UNIFIED? ☐ YES, Grade _____ Date _____ ☐ NO

LEGAL NAME OF CHILD _____ M F
Last First M Nickname (Circle)

HOME ADDRESS _____
Street City Zip Telephone

DATE OF BIRTH _____ PLACE OF BIRTH _____
Mo Day Year City State Country

SPECIAL SERVICES: Is your child currently enrolled in a special education class or receiving special support services? ☐ YES ☐ NO

If YES, check type of program(s): ☐ Resource (RSP) ☐ Special Day Class (SDC) ☐ 504 Plan ☐ Speech ☐ Hearing ☐ Vision
☐ GATE ☐ English Learner ☐ Other _____

WHAT IS YOUR CHILD'S ETHNICITY? (Please check one box) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

WHAT IS YOUR CHILD'S RACE? (Please check one or more boxes)

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 child's race to be.

- | | | |
|---|--|--|
| <input type="checkbox"/> 100=American Indian or Alaska Native | <input type="checkbox"/> 206=Laotian | <input type="checkbox"/> 303=Samoan |
| <input type="checkbox"/> 201=Chinese | <input type="checkbox"/> 207=Cambodian | <input type="checkbox"/> 304=Tahitian |
| <input type="checkbox"/> 202=Japanese | <input type="checkbox"/> 208=Hmong | <input type="checkbox"/> 399=Other Pacific Islander |
| <input type="checkbox"/> 203=Korean | <input type="checkbox"/> 299=Other Asian | <input type="checkbox"/> 400=Filipino |
| <input type="checkbox"/> 204=Vietnamese | <input type="checkbox"/> 301=Hawaiian | <input type="checkbox"/> 600=African American or Black |
| <input type="checkbox"/> 205=Asian Indian | <input type="checkbox"/> 302=Guamanian | <input type="checkbox"/> 700=White |

EVIDENCE OF BIRTH

Certified Birth Certificate _____ Family Bible Record _____
Baptismal Record _____ Passport _____
Hospital Record _____ Other _____

(FOR OFFICE USE ONLY)

Proof of residency verified by _____

Intradistrict Yes ___ No ___ Immunizations Verified ___

Interdistrict Yes ___ No ___ Home Language Survey ___

Emergency Card ___

PARENT/GUARDIAN INFORMATION

Father's Legal Name _____ Cell Phone _____

Name of Employer _____ Occupation _____ Work Phone _____

Mother's Legal Name _____ Cell Phone _____

Name of Employer _____ Occupation _____ Work Phone _____

Guardian's Legal Name _____ Cell Phone _____

Name of Employer _____ Occupation _____ Work Phone _____

Student Lives With: ___ Father ___ Mother ___ Stepfather ___ Stepmother ___ Legal Guardian ___ Other

---- Form continues on back ----

CHILDREN OF FAMILY (in order of birth)

| NAME | BIRTHDATE | RELATIONSHIP TO STUDENT | LIVING IN HOME |
|-------|-----------|-------------------------|----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

PARENT EDUCATIONAL LEVEL

Mark the response that describes the educational level of your most educated parent.

- ☐ Not a high school graduate
- ☐ High school graduate
- ☐ Some college
- ☐ College graduate (B.A. or B.S. degree)
- ☐ Graduate school/post graduate training
- ☐ Declined to state or unknown

RESIDENCE

This information will be used to determine if your child qualifies for any additional assistance under the Federal Elementary and Secondary Education Act.

Where is your child currently living? (Mark one response only.)

- ☐ In a single family residence: house, apartment, condominium, or mobile home
- ☐ Family is living with friends or other family members (due to cultural, familial, or convenience)

- ☐ Living in a Temporary Shelter (homeless shelters or Children's Emergency Shelter which includes foster students awaiting placement)
- ☐ Living in Hotels/Motels
- ☐ Living in a Temporary Doubled-up housing situation due to loss of housing, economic hardship, or similar reason (living with friends or relatives, runaways or unaccompanied youth)
- ☐ Living in a Temporary Unsheltered situation (vehicles, trailer parks or tent/campgrounds)

- ☐ Foster Student living in a Foster Family Home (in Foster Care System) or Kinship Placement (living with a relative or friend)
- ☐ Foster Student living in a Licensed Children's Institution

- ☐ Other: _____

My signature certifies that the home address listed above is my true legal residence as parent/guardian of the above-named student. I understand that failure to provide true and correct residential information may result in the disenrollment of the above-named student. I further understand that, for those students participating in athletics, failure to provide true and correct residential information may result in the immediate removal of the above-named student from the team, and that residential ineligibility may cause the team to forfeit all contests in which the student has participated.

Parent/Guardian Signature

Date

ROCKLIN UNIFIED SCHOOL DISTRICT STUDENT EMERGENCY INFORMATION CARD

Name child uses _____ Grade _____ Birth Date _____ Teacher _____ ED _____
Last name First name
Child's legal name _____ Birth Place _____ Male/Female (Circle one)
Last name First name Middle name City State
Home address _____
Street Apt # City Zip Code
Home telephone _____ Email address _____

Parent(s) or guardian(s) child lives with _____

If parents are separated or divorced, to whom has physical custody been granted? _____

Father _____ Check one: ☐ Natural ☐ Step ☐ Guardian/Foster
Employer _____ Business phone _____ Cell/Pager _____

Mother _____ Check one: ☐ Natural ☐ Step ☐ Guardian/Foster
Employer _____ Business phone _____ Cell/Pager _____

Other siblings attending RUSD schools:

| Name | School | Grade |
|------|--------|-------|
| | | |
| | | |

If my child is ill, has an emergency, or is suspended and I cannot be reached, please call and release my child to (must be over 18 years old and have ID):

1. Name _____ Phone _____ Relationship _____
or
2. Name _____ Phone _____ Relationship _____

Child's physician _____ Phone _____ Insurance _____ Hospital preference _____

- ☐ 1. In the event of an emergency, when a parent or guardian is unavailable, I authorize school personnel to make arrangements for my child to receive medical or hospital care, including necessary transportation, in accordance with their best judgment. I authorize the physician named above to undertake such care and treatment as is considered necessary. In the event said physician is unavailable, I authorize such care and treatment to be performed by a licensed physician or surgeon. I agree to pay all costs incurred as a result of the foregoing.
- ☐ 2. I do not choose the above statement and desire the following action in the event of an emergency and we cannot be reached.

PLEASE CHECK THE FOLLOWING ITEMS IF THEY PERTAIN TO YOUR CHILD

There are no known health problems ☐

EYES

Wears glasses ☐ To be worn at all times ☐
Wears contacts ☐ To be worn at all times ☐
Comments: _____

EARS

Has a hearing problem ☐
Has tubes in ear(s) ☐
Uses hearing aid ☐
Comments: _____
Requires preferential seating ☐ Due to: _____
Currently taking prescribed medication ☐
Prescribing physician: _____
Medication: _____
For: _____
Medication needs be taken at school ☐

GENERAL HEALTH

Has the following condition(s):
Diabetes ☐ Fainting spells ☐
Epilepsy ☐ Heart Condition ☐
Migraines ☐ Asthma ☐
Hyperactive (ADHD) ☐
Allergies ☐ (Describe) _____
Allergic to bee stings ☐ (Describe) _____
Other: _____
Has a life threatening medical condition ☐
Explain: _____
Has a physical condition which limits participation in physical education or classroom activities ☐
Explain: _____

BOTH PARENTS/GUARDIANS MUST SIGN

By signing below, the parents/guardians certify under penalty of perjury that the information given on this form is true and accurate.

| | | | |
|-----------------------------------|------------|-----------------------------------|------------|
| Parent/Guardian's signature _____ | Date _____ | Parent/Guardian's signature _____ | Date _____ |
|-----------------------------------|------------|-----------------------------------|------------|

PLEASE READ: California Education Code 49408 indicates that for the protection of a pupil's health and welfare, the governing board of a school district requires the parent or legal guardian of the pupil to verify and keep current at the pupil's school of attendance, emergency information including the home address and telephone number, business address and telephone number of the parents or guardian, and the name, address, and telephone number of a relative or friend who is authorized to care for the pupil in any emergency situation if the parent or legal guardian cannot be reached. California Education Code makes it mandatory that every student be provided with physical education. If, at any time, your child is ill or has a condition which you feel requires being excused from activity for more than 5 school days, an explanatory note is required from your child's health advisor.

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 a language other than English is spoken in the home, the district is required to assess your son/daughter.

ROCKLIN UNIFIED SCHOOL DISTRICT HOME LANGUAGE SURVEY – ENGLISH

(Please fill out a form for every student at the time of registration)

School: _____ School Start Date: _____

Student's Name: _____
First name Last name ☐ Male ☐ Female Grade: _____

Birth Date: _____ Place of Birth: _____
City State Country

Date first enrolled in a K-12 U.S. school: _____

Date first enrolled in a K-12 California school: _____

Name of previous K-12 school attended: _____

Location of previous K-12 school attended: _____
City State Zip code

Please answer the following questions as they apply to your son/daughter.

1. Which language did your son/daughter learn when he/she first began to speak? _____
2. What language does your son/daughter most frequently use at home? _____
3. What language do you use most frequently to speak to your son/daughter? _____
4. Name the language most often spoken by the adults at home: _____

For School Office use only:

Send/fax (630-2226) a copy of this form to the DO, attn: English Learner Program Specialist if:

- Place of birth is outside the U.S. and/or
- Any of questions 1-4 above are marked a language other than English

Date sent _____ Initials _____

For District Office use only:

| | <u>Date</u> | <u>Initials</u> |
|--------------------------|-------------|-----------------|
| Requested previous CELDT | _____ | _____ |
| Updated in Aeries | _____ | _____ |
| Updated in ESS | _____ | _____ |

Rocklin Unified School District

2615 Sierra Meadows Drive • Rocklin, CA 95677

Phone (916) 624-2428 • FAX (916) 624-7246



Roger Stock, Superintendent
Todd Cutler, Deputy Superintendent

Barbara Patterson, Associate Superintendent
Michael S. Garrison, Assistant Superintendent

January 10, 2014

Dear Parent:

Welcome to Kindergarten! There are several items in the registration packet that we will need from you in order for your child to start school in the fall.

- Please take the time to completely fill out the health history form. The school nurse needs to know if there are any medical conditions that may impact your child's ability to learn and be safe at school.
- If your child needs to take any medications at school, prescription or over-the-counter, a physician's order must accompany the medication. You may obtain a medication form from your child's school.
- Rocklin Unified School District recommends that each kindergartner have a physical examination prior to starting school. *State law requires that, within 90 days of entrance into the first grade, the child's parent/guardian must provide a certificate documenting that the child has received a health checkup within the previous 18 months.*
- State law requires an Oral Health assessment from your child's dentist. This assessment is due by May 31 of the kindergarten year. Your child may be excused from this requirement (*see details on the enclosed Oral Health Assessment Form*).
- Your child will need proof of the following immunizations in order to register and start kindergarten in the fall. If your child is in the process of completing some immunizations, then he/she will be conditionally placed in a class until documentation can be provided.
 - **Polio**- 4 doses at any age, but 3 doses are enough if at least one dose was given on or after the 4th birthday for children aged 4-6 years entering kindergarten.
 - **DTP/DtaP/DT/Td** -5 doses at any age, but 4 doses are enough if at least one dose was given on or after the 4th birthday for children entering kindergarten.
 - **MMR**- 2 doses, both given on or after the 1st birthday for kindergarten entry.
 - **Hepatitis B** -3 doses for kindergarten entry.
 - **Varicella**- 1 dose for kindergarten entry or a note from a doctor indicating the child has had the Varicella virus (chicken pox).

If you have any questions, or would like to discuss any health issues regarding your child, please feel free to contact the Health Office at your child's school. Thank you.

Sincerely,

Janna Cambra

Director of Special Education/Support Programs

ROCKLIN UNIFIED SCHOOL DISTRICT
RECORD OF SPECIAL EDUCATION PROGRAMS

To provide continuity in your child's educational program, it is important that we be made aware of any Special Education services he/she has been receiving. Please provide the following information to help us expedite your child's proper placement.

Name of Student _____

Birth Date _____ Grade _____

My Child: (Please initial all statements that are applicable.)

_____ is not participating in any Special Education programs

_____ is currently in a Special Day Class (SDC)

_____ is currently in a Resource Specialist Program (RSP)

_____ is currently receiving Speech/Language Therapy

_____ is currently receiving Adaptive Physical Education

_____ is currently receiving Occupational Therapy (OT)

_____ was referred and/or evaluated to receive Special Education services at
_____ School in _____ School District

_____ has a Section 504 Accommodation Plan

_____ has received Special Education services in the past

_____ has received Section 504 Accommodation in the past

If your child is currently in any Special Education program, do you have a copy of the current IEP? ☐ Yes ☐ No If yes, please provide a copy.

If your child has a Section 504 Plan, do you have a copy? ☐ Yes ☐ No If yes, please provide a copy.

Comments: _____

Parent/Guardian Signature

Date

For School Office use:

1. If the student is currently receiving Special Ed services, **notify the Special Education teacher (RSP or Speech) or the Program Specialist (SDC)**, and forward to the appropriate Special Education teacher or support staff.
2. If the student currently has a Section 504 Accommodation Plan, **notify the 504 Plan coordinator**, and forward to the classroom teacher.
3. If the student is not currently receiving Special Ed services, file this form in the cum folder.

ROCKLIN UNIFIED SCHOOL DISTRICT
HEALTH AND DEVELOPMENTAL INFORMATION

SCHOOL _____ TEACHER _____ GRADE _____
 NAME _____ BIRTH DATE _____ M F (circle)
 ADDRESS _____ HOME PHONE # _____
 PARENTS' NAMES _____ WORK/CELL #s _____

| | | |
|---|--|--|
| This section to be completed only for Kindergarten students and students new to Rocklin Unified | BIRTH: Full term _____ Premature _____ Birth Weight _____ | |
| | Were there any problems during pregnancy? _____ | |
| | Were there any problems during/after birth? _____ | |
| | Use of prescription/non-prescription drugs during pregnancy? _____ | |
| | DEVELOPMENTAL INFORMATION: Feeding problems? _____ | |
| | When did baby sit alone? _____ walk _____ talk (1-2 words) _____ talk in sentences _____ toilet trained _____ | |

MEDICAL HISTORY: Has your child had a problem in the following areas? (Comment on back of form if "yes" – when, treatment, etc.)

| | Yes | No | | Yes | No |
|-----------------------------|-----|----|-------------------------------------|-----|----|
| Genetic Disorder | | | Family History of Learning Problems | | |
| Physical Disability | | | Fainting Spells/Dizziness | | |
| Diabetes | | | Asthma | | |
| Intestinal/Stomach Problems | | | Headaches | | |
| Heart Problems | | | Eye/Vision Problems | | |
| Anemia/Blood Disorders | | | Ear/Hearing Problems | | |
| Tumors | | | Frequent Colds | | |
| Leukemia/Cancer | | | Nosebleeds | | |
| Hepatitis/CMV | | | Frequent Urination/Bed Wetting | | |
| Encephalitis/Meningitis | | | Skin Problems | | |
| Convulsions/Seizures | | | Eating Problems/Appetite | | |

Allergies: _____
 How does this allergy show itself? _____
 Is emergency medication required for this allergy (if so, what?) _____
 What medication does your child take on a regular basis? _____
 Has your child been hospitalized or treated for a serious illness, high fever or accident? If so, when, and what was the outcome? _____
 Operations: _____
 Does child wear prescription glasses? Yes _____ No _____
 Glasses first prescribed _____
 How would you describe your child's general health? Good _____ Poor _____
 Comments _____
 Summary of current health conditions _____
 Is there any additional information which would be of help in promoting your child's welfare and enhancing his/her education? _____
PHYSICIAN'S NAME _____ Date/reason for last visit _____
DENTIST'S NAME _____ Date/reason for last visit _____
EYE DR.'S NAME _____ Date/reason for last visit _____
Date _____ **Parent/Guardian Signature** _____

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

| | | | |
|------------------------|-------|----------|---------------------------|
| CHILD'S NAME—Last | First | Middle | BIRTH DATE—Month/Day/Year |
| ADDRESS—Number, Street | City | ZIP code | SCHOOL |

PART II TO BE FILLED OUT BY HEALTH EXAMINER**HEALTH EXAMINATION**

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

| REQUIRED TESTS/EVALUATIONS | DATE (mm/dd/yy) |
|---------------------------------|-----------------|
| Health History | / / |
| Physical Examination | / / |
| Dental Assessment | / / |
| Nutritional Assessment | / / |
| Developmental Assessment | / / |
| Vision Screening | / / |
| Audiometric (hearing) Screening | / / |
| Tuberculin Test (Mantoux/PPD) | / / |
| Blood Test (for anemia) | / / |
| Urine Test | / / |
| Blood Lead Test | / / |
| Other | / / |

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.

Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

| VACCINE | DATE EACH DOSE WAS GIVEN | | | | |
|---|--------------------------|--------|-------|--------|-------|
| | First | Second | Third | Fourth | Fifth |
| POLIO (OPV or IPV) | | | | | |
| DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only) | | | | | |
| MMR (measles, mumps, and rubella) | | | | | |
| HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only) | | | | | |
| HEPATITIS B | | | | | |
| VARICELLA (Chickenpox) | | | | | |
| OTHER | | | | | |
| OTHER | | | | | |

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER (optional) and RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN**RESULTS AND RECOMMENDATIONS**

Fill out if patient or guardian has signed the release of health information.

- ☐ Examination shows no condition of concern to school program activities.
- ☐ Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: *(please explain)*

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

☐ Please check this box if you **do not** want the health examiner to fill out Part III.

Signature of parent or guardian _____ Date _____

Name, address, and telephone number of health examiner

Signature of health examiner _____ Date _____

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.

CHDP website: www.dhs.ca.gov/chdp

INFORME DEL EXAMEN DE SALUD PARA EL INGRESO A LA ESCUELA

Para proteger la salud de los niños, la ley de California exige que antes de ingresar a la escuela todos los niños tengan un examen médico de salud. Por favor, pídale al examinador de salud que llene este informe y entregelo a la escuela—este informe será archivado por la escuela en forma confidencial.

PARTE I PARA SER LLENADO POR EL PADRE/LA MADRE O EL GUARDIÁN

| | | | |
|-------------------------------|---------------|----------------|---------------------------------|
| NOMBRE DEL NIÑO/NIÑA—Apellido | Primer Nombre | Segundo Nombre | FECHA DE NACIMIENTO—Mes/Día/Año |
| DOMICILIO—Número y Calle | Ciudad | Zona Postal | Escuela |

PARTE II PARA SER LLENADO POR EL EXAMINADOR DE SALUD**EXAMEN DE SALUD**

AVISO: Todas las pruebas y evaluaciones excepto el análisis de sangre para el plomo deben ser hechas después de la edad de 4 años y 3 meses.

| PRUEBAS Y EVALUACIONES REQUERIDAS | FECHA(mm/dd/aa) |
|---------------------------------------|-----------------|
| Historia de Salud | / / |
| Examen Físico | / / |
| Evaluación de Dientes | / / |
| Evaluación de Nutrición | / / |
| Evaluación del Desarrollo | / / |
| Pruebas Visuales | / / |
| Pruebas con Audiómetro (auditivas) | / / |
| Pruebas con Tuberculina (Mantoux/PPD) | / / |
| Análisis de Sangre (para anemia) | / / |
| Análisis de Orina | / / |
| Análisis de Sangre para el plomo | / / |
| Otra | / / |

REGISTRO DE INMUNIZACIONES

Aviso al Examinador: Por favor dé a la familia, una vez completado, o a la fecha, el Registro de Inmunización de California en papel amarillo.

Aviso a la Escuela: Por favor apunte las fechas de inmunización sobre el Registro de Inmunización de la escuela de California en papel azul.

| VACUNA | FECHA EN QUE CADA DOSIS FUE DADA | | | | |
|---|----------------------------------|---------|---------|--------|--------|
| | Primero | Segundo | Tercero | Quarto | Quinto |
| POLIO (OPV o IPV) | | | | | |
| DTaP/DTP/DT/Td (difteria, tétano y [acelular] pertusis [tos ferina]) O (tétano y difteria solamente) | | | | | |
| MMR (sarampión, paperas, rubéola) | | | | | |
| HIB MENINGITIS (Hemófilo, Tipo B) (Requerida para centros de cuidado para niños y centros preescolares solamente) | | | | | |
| HEPATITIS B | | | | | |
| VARICELLA (Viruelas locas) | | | | | |
| OTRA | | | | | |
| OTRA | | | | | |

PARTE III INFORMACIÓN ADICIONAL DEL EXAMINADOR DE SALUD (optional)**y PERMISO PARA DIVULGAR (DISTRIBUIR) EL INFORME DE SALUD****RESULTADOS Y RECOMENDACIONES**

Llene esta parte si el padre/la madre o el guardián ha firmado el consentimiento para divulgar (distribuir) la información de salud de su niño/niña.

- ☐ El examen reveló que no hay condiciones que conciernen las actividades de los programas escolares.
- ☐ Las condiciones encontradas en el examen o después de una evaluación posterior que son de importancia para la actividad escolar o física son: (por favor explique)

Yo le doy permiso al examinador de salud para que comparta con la escuela la información adicional de este examen como es explicado en la Parte III.

☐ Por favor marque esta caja si Ud. no desea que el examinador llene la Parte III.

➤ _____
Firma del padre/madre o guardián

Fecha

Nombre, domicilio, y teléfono del examinador

➤ _____
Firma del examinador de salud

Fecha

Si su niño o niña no puede obtener el examen de salud llame al Programa de Salud para la Prevención de Incapacidades de Niños y Jovenes (Child Health and Disability Prevention Program) en su departamento de salud local. Si Ud. no desea que su niño(a) tenga un examen de salud, puede firmar la orden (PM 171 B), formulario que se consigue en la escuela de su niño(a).

CHDP website: www.dhs.ca.gov/chdp

CALIFORNIA SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent record (cumulative folder) as defined in Section 49068 of the Education Code and shall transfer with that record. Local health departments shall have access to this record in schools, child care facilities, and family day care homes.

This record must be completed by school and child care personnel from an immunization record provided by parent or guardian. See reverse side for instructions.

Student Name _____ Sex: ☐ M ☐ F ☐ Birthdate _____ Place of Birth _____

Name of Parent or Guardian _____ Address _____

Telephone _____ City _____ ZIP _____

Daytime _____ Nighttime _____

Race/Ethnicity:

- ☐ White, not Hispanic
☐ Hispanic
☐ Black
☐ Other

| VACCINE | DATE EACH DOSE WAS GIVEN | | | | |
|--|--------------------------|-----|-----|-----|---------|
| | 1st | 2nd | 3rd | 4th | 5th |
| POLIO (OPV or IPV) | | | | | Booster |
| DTP/DTaP/DT/Td (Diphtheria, tetanus and [acellular] pertussis OR tetanus and diphtheria only) | | | | | |
| MMR (Measles, mumps, and rubella) | | | | | |
| HIB (Required only for child care and preschool) | | | | | |
| HEPATITIS B | | | | | |
| VARICELLA (Chickenpox) | | | | | |
| HEPATITIS A (Not required) | | | | | |

I. DOCUMENTATION

I certify that I reviewed a record of this child's immunizations and transcribed it accurately:

Date _____

Staff Signature _____

Record Presented was:

- ☐ Yellow California Immunization Record
☐ Out-of-state school record
☐ Other immunization record

Specify _____

II. STATUS OF REQUIREMENTS

- ☐ A. All Requirements are met.

Date _____

- ☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

Exemption was granted for:

- ☐ C. Medical Reasons—Permanent
☐ D. Medical Reasons—Temporary
☐ E. Personal Beliefs

III. 7th GRADE ENTRY

- ☐ A. All Requirements are met.

Name _____ Date _____

- ☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

Name _____ Date _____

| | | | | | | | |
|------------|--|------------|-----------|----------|--|---|---|
| TB | Type* | Date given | Date read | mm indur | Impression | CHEST X-RAY (Necessary if skin test positive) | |
| SKIN TESTS | <input type="checkbox"/> PPD-Mantoux <input type="checkbox"/> Other | | | | <input type="checkbox"/> Pos <input type="checkbox"/> Neg | Film date: _____ | Impression: <input type="checkbox"/> normal <input type="checkbox"/> abnormal |
| | <input type="checkbox"/> PPD-Mantoux <input type="checkbox"/> Other | | | | <input type="checkbox"/> Pos <input type="checkbox"/> Neg | Person is free of communicable tuberculosis: <input type="checkbox"/> yes <input type="checkbox"/> no | |

*If required for school entry, must be Mantoux unless exception granted by local health department.

INSTRUCTIONS FOR SCHOOL OR CHILD CARE STAFF

1. Complete child's name and address information section, or ask parent or guardian to complete this section only. (This form is not to be sent home or given to parents to complete.)
2. School or child care personnel then fill in date (month/day/year) of each immunization the student has received from the Immunization Record presented by the parent or guardian. (If the date consists only of month and year for some doses, fill in month/xx/year; however, if either measles, rubella or mumps (or MMR) was received in the month of the first birthday, month/day/year is required.)
3. Determine if immunization requirements have been met, using the California "Immunization Requirements for Grades K-12," or "Immunization Requirements for Child Care," (available from Immunization Coordinators in local health departments), or other requirements guide.
4. Complete the Documentation and Status of Requirements box
 - A. Fill in date and your signature as the staff member who reviewed and transcribed the immunization record presented by the parent or guardian. Check which type of record was presented.
 - B. If the child has met all immunization requirements, check box A and write in date.
 - C. If the child has not met all requirements, check box B. Child can be admitted only if up-to-date, e.g., no immunizations due currently. The child must be followed up as indicated in the "Guide to Immunization Requirements."
 - D. If a child is to be exempted for medical reasons, a doctor's written statement is required; the statement must include which immunization(s) is to be exempted and the specific nature and probable duration of the medical condition. If the medical exemption is permanent, the requirement for the designated immunization(s) is met: check box A and box C.* If the medical exemption is temporary, check box B and box D; this child must be followed up.*
 - E. If a child is to be exempted for reasons of personal beliefs, the parent or guardian must sign and date the affidavit below. No other parents should sign this affidavit. All requirements are met; check box A and box E.*

PERSONAL BELIEFS AFFIDAVIT TO BE SIGNED BY PARENT OR GUARDIAN—IMMUNIZATION

I hereby request exemption of the child, named on the front, from the immunization requirements for school/child care entry because all or some immunizations are contrary to my beliefs. I understand that in case of an outbreak of any one of these diseases, the child may be temporarily excluded from attending for his/her protection.

CREENCIAS PERSONALES: ESTA DECLARACIÓN JURADA DEBE SER FIRMADA POR EL PADRE O LA MADRE O EL GUARDIÁN
 Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para vacunas de la entrada a la escuela/guardería ya que algunas o todas de las vacunas son opuestas a mis creencias. Comprendo que en caso de un brote en la comunidad de alguna de estas enfermedades, mi hijo puede ser excluido temporalmente de la escuela/guardería por su propia protección.

Signature (Firma) _____

Date (Fecha) _____

Applicable only in those jurisdictions where the Tuberculosis Assessment is required for school entry

Personal Beliefs Affidavit to be Signed by Parent or Guardian—Tuberculosis

I hereby request exemption of the child named on the front from the tuberculosis assessment requirement for school/child care center entry because this procedure(s) is contrary to my beliefs. I understand that should there be cause to believe that my child is infected with active tuberculosis or should there be a tuberculosis outbreak, my child may be temporarily excluded from school.

Creencias Personales: Declaración Jurada Debe ser Firmada por el Padre o la Madre o el Guardián

Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para la evaluación de la tuberculosis (tisis) de la entrada a la escuela ya que esta evaluación es opuesta a mis creencias. Comprendo que si hay razón para sospechar que mi hijo sufra de la tuberculosis, mi hijo puede ser excluido de la escuela.

Signature (Firma) _____

Date (Fecha) _____

* Names of all children who are exempt should be maintained on an exempt roster for immediate identification in case of disease outbreak in the community.

Rocklin Unified School District

2615 Sierra Meadows Drive • Rocklin, CA 95677

Phone • (916) 624-2428 Fax • (916) 624-7246



Roger Stock, Superintendent
Todd Cutler, Deputy Superintendent

Barbara Patterson, Associate Superintendent
Michael S. Garrison, Assistant Superintendent

Dear Parent/Guardian:

To make sure your child is ready for school, California law, *Education Code* Section 49452.8, now requires that your child have an oral health assessment (dental check-up) by May 31 in either kindergarten or first grade, whichever is his or her first year in public school. Assessments that have happened within the 12 months before your child enters school also meet this requirement. The law specifies that the assessment must be done by a licensed dentist or other licensed or registered dental health professional.

Take the attached Oral Health Assessment/Waiver Request form to the dental office, as it will be needed for your child's check-up. If you cannot take your child for this required assessment, please indicate the reason for this in Section 3 of the form. You can get more copies of the necessary form at your child's school or online from the California Department of Education's Web site at <http://www.cde.ca.gov/ls/he/hn/>.

California law requires schools to maintain the privacy of students' health information. Your child's identity will not be associated with any report produced as a result of this requirement.

The following resources will help you find a dentist and complete this requirement for your child:

1. Medi-Cal/Denti-Cal's toll-free number or Web site can help you to find a dentist who takes Denti-Cal: 1-800-322-6384; <http://www.denti-cal.ca.gov>. For help enrolling your child in Medi-Cal/Denti-Cal, contact Placer County Health and Human Services, 11519 B Avenue, Auburn, CA 95603 (530-889-7610) or the Roseville Office (916-784-6000).
2. Healthy Families' toll-free number or Web site can help you to find a dentist who takes Healthy Families insurance or to find out if your child can enroll in the program: 1-800-880-5305 or <http://www.healthyfamilies.ca.gov/hfhome.asp>.
3. For additional resources that may be helpful, contact Placer County Health and Human Services, 11519 B Avenue, Auburn, CA 95603 (530-889-7610) or the Roseville Office (916-784-6000).

Remember, your child is not healthy and ready for school if he or she has poor dental health! Here is important advice to help your child stay healthy:

- Take your child to the dentist twice a year.
- Choose healthy foods for the entire family. Fresh foods are usually the healthiest foods.
- Brush teeth at least twice a day with toothpaste that contains fluoride.
- Limit candy and sweet drinks, such as punch or soda. Sweet drinks and candy contain a lot of sugar, which causes cavities and replaces important nutrients in your child's diet. Sweet drinks and candy also contribute to weight problems, which may lead to other diseases, such as diabetes. The less candy and sweet drinks, the better!

Baby teeth are very important. They are not just teeth that will fall out. Children need their teeth to eat properly, talk, smile, and feel good about themselves. Children with cavities may have difficulty eating, stop smiling, and have problems paying attention and learning at school. Tooth decay is an infection that does not heal and can be painful if left without treatment. If cavities are not treated, children can become sick enough to require emergency room treatment, and their adult teeth may be permanently damaged.

Many things influence a child's progress and success in school, including health. Children must be healthy to learn, and children with cavities are not healthy. Cavities are preventable, but they affect more children than any other chronic disease.

If you have questions about the new oral health assessment requirement, please contact the school site health office or the district health services supervisor.

Sincerely,

A handwritten signature in blue ink, appearing to read "Roger Stock", with a large, stylized initial "R" and a long, sweeping horizontal line extending to the right.

Roger Stock, *Superintendent*

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31 of his/her first year in public school. A California licensed dental professional operating within his scope of practice must perform the check-up and fill out Section 2 of this form. If your child had a dental check-up in the 12 months before he/she started school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

Section 1: Child's Information *(To be filled out by parent or guardian)*

| | | | |
|-----------------------|--|-----------------|---|
| Child's First Name: | Last Name: | Middle Initial: | Child's birth date: |
| Address: | | | Apt.: |
| City: | | | ZIP code: |
| School Name: | Teacher: | Grade: | Child's sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Parent/Guardian Name: | Child's race/ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other _____ <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown | | |

Section 2: Oral Health Data Collection *(To be filled out by a California licensed dental professional)*

IMPORTANT NOTE: Consider each box separately. Mark each box.

| | | | |
|--|--|--|--|
| Assessment Date: | Caries Experience (Visible decay and/or fillings present) <input type="checkbox"/> Yes <input type="checkbox"/> No | Visible Decay Present: <input type="checkbox"/> Yes <input type="checkbox"/> No | Treatment Urgency: <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) <input type="checkbox"/> Urgent care needed (pain, infection, swelling or soft tissue lesions) |
| | | | |
| _____ Licensed Dental Professional Signature | | _____ CA License Number | _____ Date |

Section 3: Waiver of Oral Health Assessment Requirement

(To be filled out by parent or guardian asking to be excused from this requirement)

Please excuse my child from the dental check-up because: (Check the box that best describes the reason)

- ☐ I am unable to find a dental office that will take my child's dental insurance plan.
My child's dental insurance plan is:
☐ Medi-Cal/Denti-Cal ☐ Healthy Families ☐ Healthy Kids ☐ Other _____ ☐ None
- ☐ I cannot afford a dental check-up for my child.
- ☐ I do not want my child to receive a dental check-up.
- Optional: other reasons my child could not get a dental check-up: _____

If asking to be excused from this requirement: ► _____
Signature of parent or guardian
Date

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school.

Return this form to the school *no later than May 31* of your child's first school year.
Original to be kept in child's school record.