Enrollment Packet Information

Thank you for your interest in Sierra Vista K-8. The school offers additional educational option for Vacaville students and families. Sierra Vista K-8 is a public school, which is open to all students residing in Vacaville Unified boundaries. Interdistrict Agreements for student living outside the district attendance boundaries will also be considered.

The required enrollment forms need to be completed and submitted on or before February 16, 2016 at 5:00 PM to be included for consideration. The completed packet should be returned to the Educational Services Center, 401 Nut Tree Road, Vacaville, 95687. Packets will be time stamped upon submission in case a lottery is needed.

A. Currently Enrolled Vacaville Unified School District Students
If you reside in the district boundaries and your child is a current VUSD student school, complete only the Student Enrollment Information and Student Emergency Information forms. Upon completion, return the two forms to the Educational Services Center, 401 Nut Tree Road, Vacaville 95687.

B. New First – Eighth Grade Students for the 2016 -17 School Year
If your child will be a new VUSD First Grade – Eighth Grade student next year, and you live within the VUSD boundaries, please complete the Student Enrollment Information and Student Emergency Information forms and include copies of the following items:
1) Birth certificate;
2) Immunization record; and
3) Proof of residence address, e.g., PG&E bill or cable bill.
4) Home Language Survey form

C. New Kindergarten Students for the 2016 -17 School Year
If your child will be a new VUSD Kindergarten student next year, please complete the Student Enrollment Information and Student Emergency Information forms and include copies of the following items:
1) Birth certificate;
2) Immunization record;
3) Proof of residence address, e.g., PG&E bill or cable bill;
4) Proof of a physical exam after your child was 4 years, 3 months old or written proof of an appointment for an exam.
5) Proof of a dental exam must be supplied to the school by May 31, 2017 for students registering for kindergarten.
6) Home Language Survey form

If your child currently attends Transitional Kindergarten (TK) in a VUSD school, please only complete the 2 forms for currently enrolled students. Upon completion, return the forms to the Educational Services Center, 401 Nut Tree Road, Vacaville 95687.

C. Out of District Students
If you reside out of the VUSD boundaries, please complete the information listed above in Section B or C and begin the process of getting an approved Interdistrict Agreement from your district of residence. This agreement is required for new and renewal interdistrict students. Parents should complete an application for 2016-2017 school year starting at their district of residence. The approved agreement must be submitted to VUSD by May 13, 2016.
STUDENT LEGAL NAME ______________________

Last  First  Middle  Male/Female

RESIDENTIAL ADDRESS ______________________

City / State / Zip ______________________ Phone ______________________

GRADE LEVEL ______________________ Student also goes by the name(s): ______________________

BIRTH PLACE: City / State / Country ______________________ BIRTH DATE: ______/____/____

Last Two Schools Attended: (Most recent first)

Name of School ______________________

Grades Attended ______________________

Address ______________________

City/State/ Zip ______________________ Phone ______________________

Name of School ______________________

Grades Attended ______________________

Address ______________________

City/State/ Zip ______________________ Phone ______________________

Student continuously enrolled in the Vacaville School District since grade (Circle one grade): TK  K  1  2  3  4  5  6  7  8  9  10  11  12

Grade(s) Repeated (if any) ______ Has student been expelled? ______ Yes ______ No ______

If yes: School District ______________________

KINDERGARTEN ENROLLMENT: Please check your preference for morning or afternoon class:

_____ No Preference _____ AM _____ PM

(We will make every effort to accommodate your request, however we cannot guarantee your request will be granted.)

CONFIDENTIAL INFORMATION FOR FEDERAL AND STATE REPORTS

Parent Federally Employed: ______ Yes ______ No Parent Employed on Federal Property: ______ Yes ______ No

Parent Education Level: (Please write in correct number) ______ Mother/Female Guardian ______ Father/Male Guardian

1 - Not High School Graduate  2 - High School Graduate  3 - Some College  4 - College Graduate  5 - Graduate or post-graduate

Ethnicity: Is this student Hispanic or Latino? (Select only one) ______ Yes, Hispanic or Latino ______ No, not Hispanic or Latino

Please continue to answer the following by marking one or more boxes to indicate student’s race.

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

SPECIAL SERVICES

1. Does this child have an Individualized Education Program (IEP)? ______ Yes ______ No

   If yes, please check which program applies:

   _____ SDC (Special Day Class) _____ SDC/ED (Emotionally Disturbed) _____ RSP (Resource Specialist Program)

2. Does this child have a 504 Accommodation plan? ______ Yes ______ No

3. Has this child received any other of the following special services at his/her prior school? Please check accordingly.

   _____ Speech/Language _____ GATE or other Gifted Program
   _____ English Learner _____ Other

4. Was any special testing in progress for this child at his/her prior school? ______ Yes ______ No

   If yes, please explain: ______________________

COMMENTS OR SPECIAL REQUESTS: ______________________

PARENT/GUARDIAN NAME (Please print) ______________________

PARENT/GUARDIAN SIGNATURE ______________________

DATE ______________________

FOR OFFICE USE ONLY

ENROLLMENT DATE ______________________ INITIAL TEACHER PLACEMENT ______________________ STUDENT NUMBER ______________________

Date Records Requested ______________________ 2nd Request ______________________ Dental Form ______________________ (K and 1st Grade Only)

School of Residence ______________________ Open Enrollment ______________________ Intra-District Agmt ______________________

Proof of Residence (Initial) ______________________ Verification Method ______________________ Immunization Verification ______________________

Birth date Verification (Initial) ______________________ Verification Method ______________________ Physical Form ______________________ (K and 1st Grade Only)
## VACAVILLE UNIFIED SCHOOL DISTRICT

### STUDENT EMERGENCY INFORMATION

<table>
<thead>
<tr>
<th>LEGAL Last Name</th>
<th>LEGAL First Name</th>
<th>Middle Name</th>
<th>Sex</th>
<th>Grade</th>
<th>Birth date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Also Known as</td>
<td>Parent's Main Contact #</td>
<td>Room #</td>
<td>Teacher Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete Mailing Address</td>
<td>Residential Address (if different from Mailing Address)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Email Address</td>
<td>Student Email Address</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Circle One:</th>
<th>Natural Parent</th>
<th>Step-Parent</th>
<th>Guardian</th>
<th>Grandparent</th>
<th>Circle One:</th>
<th>Natural Parent</th>
<th>Step-Parent</th>
<th>Guardian</th>
<th>Grandparent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's Name</td>
<td>Father's Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer</td>
<td>Location (City)</td>
<td>Employer</td>
<td>Location (City)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td>Email Address (if applicable)</td>
<td>Occupation</td>
<td>Email Address (if applicable)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Phone #</td>
<td>Cell Phone #</td>
<td>Work Phone #</td>
<td>Home Phone #</td>
<td>Cell Phone #</td>
<td>Work Phone #</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PARENT/GUARDIAN INFO

Student living with: [ ] Both Parents [ ] Mother [ ] Father [ ] Grandparent(s) [ ] Guardian(s) [ ] Other __________________________

Non-residential parent info: (Parent not living with student)

Name ____________________________ Phone __________________ Home Address ____________________________

_____ Please check if non-residential parent is to receive copies of report cards and school newsletters. (Available for grades 7-12 only)

### MEDICAL

<table>
<thead>
<tr>
<th>Activity Restrictions</th>
<th>Known Medical Problems (Allergies, Asthma, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Family Physician</td>
<td>Phone #</td>
</tr>
<tr>
<td>Dentist</td>
<td>Phone #</td>
</tr>
<tr>
<td>Insurance Carrier and Medical Number</td>
<td>Medications Taken</td>
</tr>
</tbody>
</table>

### EMERGENCY CONTACT INFO

List three (3) local emergency contacts who have agreed to take either temporary care of your child (in case of illness) or extended care (in case of a natural disaster, if a parent cannot be reached.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### STUDENT NOT TO BE RELEASED TO: COURT ORDER ON FILE _____ (Please attach current copy) Date Verified _____

NAME: ____________________________
RELATIONSHIP: ____________________________
Comments: ____________________________

### FAMILY INFO

Names and ages of other children.

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name (if different)</th>
<th>Birth date</th>
<th>M</th>
<th>F</th>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
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<tr>
<td>3</td>
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<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMMENTS: ____________________________

I request that my child receive first aid whenever it is deemed medically necessary. In case of emergency illness or accident involving my child, permission is hereby given for authorized school personnel to provide emergency care and/or call an ambulance.

SIGNATURE OF PARENT/GUARDIAN ____________________________ DATE ____________________________

PLEASE COMPLETE BOTH SIDES OF DOCUMENT
STUDENT HEALTH HISTORY
Please fill in all pertinent information to better serve your student's health issues.

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Birth date</th>
<th>Grade</th>
<th>M__ / F__</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date of last dental examination: _______________________

ADD/ADHD ........... Yes __ No __
Medications __________________________ □ at school □ at home

Allergies ............. Yes __ No __
Type ___________________________ Medications __________________________
Has an Epipen been prescribed? □ Yes □ No

Asthma .................. Yes __ No __
Triggered by __________________________
Medications __________________________ □ at school □ at home

Bee Stings .............. Yes __ No __
Describe reaction __________________________

Difficulty breathing: □ Yes □ No
Medications __________________________
Has an Epipen been prescribed? □ Yes □ No

Bones/Joints ............ Yes __ No __
Describe __________________________

Cerebral Palsy......... Yes __ No __
Describe any physical limitations __________________________

Child requires: □ wheelchair □ walker □ neither

Diabetes.................. Yes __ No __
Takes insulin: □ Yes □ No
Doctor __________________________ Date ________________

Epilepsy ................. Yes __ No __
Date of last seizure: __________________________
Medication __________________________

Seizures
Is student currently under a doctor's care for seizures: □ Yes □ No

Heart Condition .... Yes __ No __
Describe __________________________

Any physical restrictions __________________________

High Blood .............. Yes __ No __
Diagnosed by Doctor __________________________ Date ________________

Pressure
Medications __________________________ □ at school □ at home

Migraines................. Yes __ No __
Diagnosed by Doctor __________________________ Date ________________

Medications __________________________ □ at school □ at home

Spina Bifida ............ Yes __ No __
Child requires: □ Wheelchair □ Other __________________________

Diaper change __________________________ Catheterization __________________________

Scoliosis ................. Yes __ No __
Diagnosed by Doctor __________________________ Date ________________

List any physical limitations __________________________

Check off any of the following health concerns that pertain to the student:

Eyes ...... □ Glasses □ Contacts □ Difficulty Seeing □ Crossed eyes □ Lazy Eye □ Distance □ Reading

Ears........... □ Tubes □ Hearing aid: Right ___ Left ___ □ Wear at school □ Hearing difficulty

Comments __________________________

Other Health Problems

Comments __________________________

List any serious injuries or surgeries __________________________

List any conditions that prevents/limits P.E. participation __________________________

Special Education Services: □ Speech/Language □ Resource □ Special Day □ ED

□ Student requires special health care. Please explain __________________________

Information on this form may be shared with school staff and entered into the student information system.
 Please contact the school if you have questions, concerns or changes.

Parent Signature __________________________ Date __________________________
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. Your cooperation in helping us meet this important requirement is requested. Please answer the following questions and have your son/daughter return this form to his/her teacher.

Thank you for your help.

Name of student: ____________________________________________

Last/Apellido __________________________ First/Primero _______________

Grade/Grado __________ Place of Birth/Ciudad/Estado/Pais Natal __________

Birth date/Fecha de Nacimiento __________

Last school attended/Última escuela de asistencia:

School name/Nombre de escuela _____________________ City/Ciudad ________

State/Estado __________

Note: If a language other than English is indicated in questions 1-3, your child must be tested for English proficiency; if a language other than English is indicated only for question 4, testing is optional.

Nota: Si hay otro idioma indicado en las preguntas 1-3 que no sea inglés, su hijo/a tiene que hacer un examen de pericia en inglés; si hay un idioma que no sea inglés indicado solamente en pregunta 4, el examen es opcional.

1. Which language did your son/daughter learn when he/she began to talk? ¿Cuál idioma aprendió primero su hijo/a cuando empezó a hablar?

2. What language does your son/daughter most frequently use at home? ¿Cuál idioma usa su hijo/a más frecuentemente en casa?

3. What language do you use most frequently to speak to your son/daughter? ¿Cuál idioma usa más frecuentemente cuando habla con su hijo/a?

4. Name the language most often spoken by the adults at home. Nombre el idioma que los adultos hablan más frecuentemente en casa.

Please provide the date that your child was first enrolled in school in the United States:

La fecha de la primera vez que su hijo/a fue matriculado en una escuela en los Estados Unidos: __________________________

Has your child attended school in another country? ☐ Yes ☐ No If yes, year/s of attendance_______ Grade completed ______

¿Ha asistido su hijo/a una escuela en otro país? ☐ Sí ☐ No Si la respuesta es Sí, Año/s de Asistencia _______ Grado completado ______

_________________________________  ___________________________  ___________________________
Student Address  Phone/Teléfono  Parent/Guardian Signature

Domicilio de alumno  Firma de Padres/Guardián

Distribution: Original - To school site EL Specialist or the projects office-THE PINK COPY MUST REMAIN IN THE STUDENT CUM FOLDER
Dear Parent or Guardian:

To make sure your child is ready for school, California law, Education Code Section 49452.8, 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 your local social services agency at 211.
2. If you do not have dental insurance, call Solano Kids Insurance Program at 1-800-978-7547.
3. For additional resources that may be helpful, contact the local public health department: Available at http://www.dhs.ca.gov/mcs/medi-Calhome/countyListing.htm or call Solano County Health Services at 707-784-2120.

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 oral health assessment requirement, please contact your school nurse or Toni McCallum, VUSD Head Nurse at (707) 453-7142.

Sincerely,

[Signature]

Superintendent
VACAVILLE UNIFIED SCHOOL DISTRICT

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 (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: □ Male  □ Female

Parent/Guardian Name:  Child’s race/ethnicity:

□ White  □ Black/African American  □ Hispanic/Latino  □ Asian
□ Native American  □ Multi-racial  □ Other _____________
□ Native Hawaiian/Pacific Islander  □ Unknown

Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

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

<table>
<thead>
<tr>
<th>Assessment Date:</th>
<th>Visible decay and/or fillings present:</th>
<th>Visible Decay Present:</th>
<th>Treatment Urgency:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>□ No obvious problem found</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Urgent care needed (pain, infection, swelling or soft tissue lesions)</td>
</tr>
</tbody>
</table>

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.
IMPORTANT NOTICE

New legislation (SB 277) states that, as of January 1, 2016, personal belief exemptions for state-mandated immunizations will no longer be accepted when registering students for school. Parents who choose not to immunize their student have the option of home schooling or an independent study program. More information about SB 277 is available at shotsforschool.org.
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

<table>
<thead>
<tr>
<th>CHILD'S NAME—Last</th>
<th>First</th>
<th>Middle</th>
<th>BIRTH DATE—Month/Day/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS—Number, Street</td>
<td>City</td>
<td>ZIP code</td>
<td>SCHOOL</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>REQUIRED TESTS/EVALUATIONS</th>
<th>DATE (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health History</td>
<td></td>
</tr>
<tr>
<td>Physical Examination</td>
<td></td>
</tr>
<tr>
<td>Dental Assessment</td>
<td></td>
</tr>
<tr>
<td>Nutritional Assessment</td>
<td></td>
</tr>
<tr>
<td>Developmental Assessment</td>
<td></td>
</tr>
<tr>
<td>Vision Screening</td>
<td></td>
</tr>
<tr>
<td>Audiometric (hearing) Screening</td>
<td></td>
</tr>
<tr>
<td>Tuberculin Test (Mantoux/PPD)</td>
<td></td>
</tr>
<tr>
<td>Blood Test (for anemia)</td>
<td></td>
</tr>
<tr>
<td>Urine Test</td>
<td></td>
</tr>
<tr>
<td>Blood Lead Test</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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).

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DATE EACH DOSE WAS GIVEN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First</td>
</tr>
<tr>
<td>POLIO (OPV or IPV)</td>
<td></td>
</tr>
<tr>
<td>DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular pertussis]) OR (tetanus and diphtheria only)</td>
<td></td>
</tr>
<tr>
<td>MMR (measles, mumps, and rubella)</td>
<td></td>
</tr>
<tr>
<td>HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)</td>
<td></td>
</tr>
<tr>
<td>HEPATITIS B</td>
<td></td>
</tr>
<tr>
<td>VARICELLA (Chickenpox)</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
</tr>
</tbody>
</table>

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.dhcs.ca.gov/services/chdp