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.
Enrollment Guidelines

2016-2017 Enrollment Period for Lottery
Monday, January 4, 2016 – Tuesday, February 16, 2016

Enrollment packets can be picked up and submitted at the Educational Services Center
401 Nut Tree Road
Vacaville, CA 95687

The completed enrollment packets will be time-stamped for lottery purposes as they are submitted at the ESC. The complete packet should be submitted on or before Tuesday, February 16, 2016 to Kerri Lopez, Staff Secretary.

Public Lottery
Monday, February 22, 2016 at the 5:30 PM at the Educational Services Center.
(Don’t have to be present during lottery process.)

Priorities
1. Students who live within the former Sierra Vista boundary
2. Students who live within other VUSD school boundaries
3. Students who live outside the Vacaville Unified School District boundaries

Process
The lottery will start with the priorities listed above. Each student will receive a number.
If a grade level fills up, then a waiting list will be created for that grade level. Whenever a spot opens, the waiting list will be used in numbered order.
*Note: If a student’s number is chosen who has siblings then all siblings are automatically chosen as well to keep families together providing there is a space in that respective grade level.

Enrollment Period After Lottery
Enrolling on or after February 16, 2016 is a first come, first served basis and is dependent upon space availability. If no open spots are available, then a waiting list will instituted.
VACAVILLE UNIFIED SCHOOL DISTRICT

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)

<table>
<thead>
<tr>
<th>Name of School</th>
<th>Grades Attended</th>
<th>Address</th>
<th>City/State/ Zip</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>______</td>
<td>____</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>ENROLLMENT DATE</th>
<th>INITIAL TEACHER PLACEMENT</th>
<th>STUDENT NUMBER</th>
<th>Date Records Requested</th>
<th>2nd Request</th>
<th>Dental Form</th>
<th>(K and 1st Grade Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School of Residence</th>
<th>Open Enrollment</th>
<th>Intra-District Agmnt</th>
<th>Inter-District Agmnt</th>
</tr>
</thead>
<tbody>
<tr>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proof of Residence (Initial)</th>
<th>Verification Method</th>
<th>Immunization Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birth date Verification (Initial)</th>
<th>Verification Method</th>
<th>Physical Form</th>
<th>(K and 1st Grade Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
</tbody>
</table>

O:\RaeAnn\Q\Beg of Year Documents\Enrollment Form Eng-Span rev 1/14
**VACAVILLE UNIFIED SCHOOL DISTRICT**

**STUDENT EMERGENCY INFORMATION**

<table>
<thead>
<tr>
<th><strong>LEGAL</strong> Last Name</th>
<th><strong>LEGAL</strong> First Name</th>
<th>Middle Name</th>
<th>Sex</th>
<th>Grade</th>
<th>Birth date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Student Also Known as

Parent’s Main Contact #

Room #

Teacher Name

Complete Mailing Address

Residential Address (if different from Mailing Address)

Parent Email Address

Student Email Address

<table>
<thead>
<tr>
<th>Circle One: Natural Parent</th>
<th>Step-Parent</th>
<th>Guardian</th>
<th>Grandparent</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mother’s Name</th>
<th>Father’s Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employer</th>
<th>Location (City)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Email Address (if applicable)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Phone #</th>
<th>Cell Phone #</th>
<th>Work Phone #</th>
<th>Home Phone #</th>
<th>Cell Phone #</th>
<th>Work Phone #</th>
</tr>
</thead>
</table>

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)*

<table>
<thead>
<tr>
<th>Activity Restrictions</th>
<th>Known Medical Problems (Allergies, Asthma, etc.)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Local Family Physician</th>
<th>Phone #</th>
<th>Dentist</th>
<th>Phone #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Insurance Carrier and Medical Number</th>
<th>Medications Taken</th>
</tr>
</thead>
</table>

Daycare Provider

Daycare Phone

Daycare Location

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>
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<tr>
<td>2</td>
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<tr>
<td>3</td>
<td></td>
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</tr>
</tbody>
</table>

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

**NAME:**

**RELATIONSHIP:**

**Comments:**

**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>
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<td></td>
<td></td>
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<tr>
<td>2</td>
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<td>3</td>
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<td>4</td>
<td></td>
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</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>Last</th>
<th>First</th>
<th>Birth date</th>
<th>Grade</th>
<th>M / F</th>
</tr>
</thead>
</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: ____________________
  - Medications ___________________________

Seizures:
- Is student currently under a doctor’s care for seizures? □ Yes □ No

Heart Condition: Yes □ No □
- Describe ___________________________
  - Any physical restrictions ___________________________
  - Medications ___________________________ □ at school □ at home

High Blood Pressure: Yes □ No □
- Diagnosed by Doctor ___________________________ Date ___________

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 ___________

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 prevent/limit 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 ___________
Date ________________ School ________________ Teacher ________________
Room________

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.

El Código de Educación de California requiere que las escuelas determinen el idioma que se habla en el hogar de cada estudiante. Esta información es esencial para que las escuelas puedan proporcionar instrucción significativa a todos los estudiantes. Le pedimos su cooperación en ayudarnos a cumplir este importante requisito. Por favor conteste las siguientes preguntas y haga que su hijo/a devuelva esta forma a su maestro/a. Gracias por su ayuda.

Name of student:___________________________________________________________________________
Nombre de estudiante Last/Apellido First/Primero

Grade/Grado Place of Birth/Ciudad/Estado/País 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 a una escuela en otro país? ☐ Si ☐ 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/slshe/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.dent-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/CountyListing1htm 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 fluorid
- Limit candy and sweet drinks, such as punch or soda. Sweet drinks contain a lot of sugar, which causes cavities and replaces important nutrients in your child’s diet. Sweet drinks 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)

<table>
<thead>
<tr>
<th>Child’s First Name:</th>
<th>Last Name:</th>
<th>Middle Initial:</th>
<th>Child’s birth date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Apt.:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>ZIP code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School Name:</th>
<th>Teacher:</th>
<th>Grade:</th>
<th>Child’s Sex:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Male □ Female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Name:</th>
<th>Child’s race/ethnicity:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ White □ Black/African American □ Hispanic/Latino □ Asian</td>
</tr>
<tr>
<td></td>
<td>□ Native American □ Multi-racial □ Other ____________</td>
</tr>
<tr>
<td></td>
<td>□ Native Hawaiian/Pacific Islander □ Unknown</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>CA License Number</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Signature of parent or guardian</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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.

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).

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                   |         |

VACCINE  DATE EACH DOSE WAS GIVEN

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<td>POLIO (OPV or IPV)</td>
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<tr>
<td>DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)</td>
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<td>MMR (measles, mumps, and rubella)</td>
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<td>HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)</td>
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<td>HEPATITIS B</td>
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<td>VARICELLA (Chickenpox)</td>
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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

Name, address, and telephone number of health examiner

Signature of health examiner

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

State of California—Health and Human Services Agency
Department of Health Care Services
Child Health and Disability Prevention (CHDP) Program

PM 171 A (09/07) (Bilingual)