Cuyama Elementary School

661-766-2642

Welcome to Kindergarten!

Please fill out the following forms and bring them with you to your child's registration. You will need to bring your child as well as his/her birth certificate and vaccination records. Thank you

Please call the Elementary office to schedule an appointment for registration, if you haven't already done so.

Bienvenido a Kindergarten!

Por favor llene todos los siguientes formularios y traigalos a la registracion de su hijo/hija. Por favor, traiga el certificado de nacimiento y los registros de vacunacion, y traigan a su hijo/hija. Gracias.

Por favor llame a la escuela para hacer una cita para la registracion.

Emergency and Health Information

Grade:________

Student's Name (last) ___________________________ (first) ___________________________________

Birthdate_______________________________Male______Female_______

Mailing address____

Physical address____

Name of person(s) with whom student lives____

Mother's name________________________________Home phone_____________________________

Cell phone_______________________________

Place of employment__________________________Work phone______________________________

Father's name_________________________________Home phone_____________________________

Cell phone_______________________________

Place of employment__________________________ Work phone_____________________________

Alternate contact______________________________Phone ________________________________

When a child suffers a serious injury or illness while in school, first aid will be rendered in accordance with local school policies, and an immediate and continuing effort will be made to contact the parents of that child.

If parents or alternate contact cannot be reached in an emergency, please call child's physician or take my child to an available medical service facility. I am aware, however, that in most situations the physician/ medical facility cannot treat a minor child without parental permission.

Doctor's office/name and phone____

Please list anything which would limit activity or may require special care during this school year: (hearing, vision, diabetes, cardiac, epilepsy, allergies, speech, emotional problems, etc.)

____

Please list any medications which you child takes regularly:

____

DATE______________________PARENT/GUARDIAN SIGNATURE__________________________________

CUYAMA JOINT UNIFIED SCHOOL DISTRICT STUDENT REGISTRATION

GRADE

Student Last Name:

First Name:

Permanent ID:

▶ **Has your student ever attended Cuyama Joint Unified School District before?** ☐ Yes ☐ No

PLEASE PRINT – STUDENT'S LEGAL NAME

Legal First Name	Legal Middle Name	Legal Last Name	Other Legal Name (if applicable)

☐ Male ☐ Female | **Birth date:**

Month	Day	Year

Parent/Guardian First Name	Last Name	Home Phone ( )	Work Phone ( )

Parent/Guardian First Name	Last Name	Home Phone ( )	Work Phone ( )

Mailing Address	Apt#	City	State	Zip

Residence Address (house # & street name) (IF DIFFERENT)	Apt #	City	State	Zip

(P.O Box or house # & street name)

WHAT IS YOUR CHILD'S ETHNICITY? (Please check one): ☐ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race) ☐ Not Hispanic or Latino

WHAT IS YOUR CHILD'S RACE? (Please check up to five racial categories)

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 race to be.

- ☐ American Indian or Alaskan Native(100) (Persons having origins in any of the original people of North, Central or South America)
- ☐ Chinese (201)
- ☐ Japanese (202)
- ☐ Korean (203)
- ☐ Vietnamese (204)
- ☐ Asian Indian (205)
- ☐ Laotian (206)
- ☐ Cambodian (207)
- ☐ Hmong (208)
- ☐ Other Asian (299)
- ☐ Hawaiian (301)
- ☐ Guamanian (302)
- ☐ Samoan (303)
- ☐ Tahitian (304)
- ☐ Other Pacific Islander (399)
- ☐ Filipino/Filipino American (400)
- ☐ African American or Black (600)
- ☐ White (700) (Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East)

PARENT EDUCATION – Check the response that describes the education level of the **most educated parent.**

- ☐ Graduate Degree or Higher (10)
- ☐ College Graduate (11)
- ☐ Some College or Associate's Degree (12)
- ☐ High School Graduate (13)
- ☐ Not a High School Graduate (14)
- ☐ Decline to State (15)

Date child first attended school in the U.S.

Month	Day	Year

Date child first attended school in California

Month	Day	Year

BIRTHPLACE: City: ____________________ State:______ Country: ____________________

U.S. Citizen: ☐ Yes ☐ No

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THE FORM (REV 4/13)

In which language do you wish to receive written communications from the school? ☐ English ☐ Spanish

Residence – where is your child/family currently living? (federally mandated by NCLB) – **Please check appropriate box:**

☐ In a single family permanent residence (house, apartment, condo, mobile home)
☐ Doubled-up (sharing housing with other families/individuals due to economic hardship or loss) (11)
☐ In a shelter or transitional housing program (10)
☐ In a motel/hotel (09)
☐ Unsheltered (car/campsite) (12)
☐ Other (15) (please specify) ____________

Parent/Guardianship Information (with whom the student lives) – check all that apply

☐ Father ☐ Mother ☐ Both ☐ Step-Father ☐ Step-Mother ☐ Guardian ☐ Foster/Group Home ☐ Other ____________
Is the above (checked) person(s) the student's LEGAL guardian? ☐ Yes ☐ No If No, please complete a "Caregiver Affidavit"
If there is a legal custody agreement regarding this student, please check one: ☐ Joint Custody ☐ Sole Custody ☐ Guardian
Is the above (checked) person(s) a member of the Armed Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard) on active duty or full-time National Guard duty? ☐ Yes ☐ No

PLEASE COMPLETE INFORMATION BELOW FOR PARENT(S)/GUARDIAN WITH WHOM THE STUDENT LIVES:

1. ☐ Father ☐ Step Father/Guardian (check one) **Full Name:** ____________

Employer: ____________ **City:** ____________ **Daytime Phone #** (____) ____________

2. ☐ Mother ☐ Step Mother/Guardian (check one) **Full Name:** ____________

Employer: ____________ **City:** ____________ **Daytime Phone #** (____) ____________

DUPLICATE MAILING – If divorced/separated & joint custody allows duplicate mailing/information to be given to other parent, Please include their name, address, and phone number:

Full Name: ____________ **Phone #:** (   ) ____________

Mailing Address: ____________ **City:** ____________ **State:** ______ **Zip code:** ________

MOST RECENT SCHOOL ATTENDED:

School	Address/City/State/Zip	Grade(s)	Date(s)

Are there psychological or confidential reports available from your child's former school? ☐ Yes ☐ No
Has your child ever been suspended? ☐ Yes ☐ No Has your child ever been expelled? ☐ Yes ☐ No
What special services is your child receiving or has received? **(please check all boxes that apply)**
Special Education: ☐ Resource (RSP) ☐ Special Day Class (SDC) ☐ Speech/Language ☐ 504
Other: ☐ Gifted (GATE) ☐ Remedial Math ☐ Remedial Reading ☐ Counseling ☐ English Language Development
☐ Help to Improve Attendance/ Behavior ☐ Other (Specify) ____________

Signature of Parent/Guardian: ____________ Date: ____________

Proof of Birth: Type: ________ Verified by: _____	Proof of Residence: Type: ________ Verified by: _____	Proof of Immunization: Type: ________ Verified by: _____	Entry Reason:	Enroll Date:	Assigned Grade:	Permanent ID:	Blank ☐ ET ☐ RC

Student Last Name:

First Name:

Permanent ID:

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THE FORM (REV 4/13)

HEALTH HISTORY

Please Print

TODAY'S DATE ____________________

1. Student's Name ____________________ Birth Date ____________________ Boy ____ Girl ____
   Social Security # ____________________
2. Dentist Name ____________________ Dentist's Phone Number ____________________
   Date of Last Dental Exam ____________________ Results ____________________
3. Physician's Name ____________________ Physician's Phone Number ____________________
   Date of Last Physical Exam ____________________ Results ____________________
   Date of Last Vision Exam ____________________ Results ____________________
   Date of Last Hearing Test ____________________ Results ____________________
4. Current Medical Problems ____________________
5. Medical History (Circle ALL that apply)

Allergy	Chicken Pox	Severe Illness
Asthma	German Measles	Accident
Epilepsy / Seizures	Measles	Enuresis
Diabetes	Mumps	Broken Bones
Heart Disease	Scarlet Fever	Nose Bleeds
Rheumatic Fever	Whopping Cough	Ear Aches
Operations	Delayed Speech	Chronic Illness
Vision	Development	Hospitalization

   If circled any of the above, EXPLAIN ____________________

6. Is your child presently on medication? ____ If yes, What, & Why? ____________________
7. Is your child allergic to any medication? ____ If yes, Name of Medication ____________________
   Other allergies? ___ If yes, what type of allergy, & what type of reaction? ____________________
8. Other information that is important for us to know about your child such as premature birth, difficult birth, slow development, etc. ____________________
9. Other concerns ____________________
10. Involved with any agencies? CCS ____________________ Regional Center ____________________

Revised 2/05

State of California—Health and Human Services Agency

Department of Health Services
Child Health and Disability Prevention (CHDP) Program

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

PM 171 A (3/03) (Bilingual)

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 their 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 starts 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.

Assessment Date:	Caries Experience (Visible decay and/or fillings present) _ Yes _ No	Visible Decay Present: _ Yes _ No	Treatment Urgency: _ No obvious problem found _ Early dental care recommended (Caries without pain or infection or child would benefit from sealants or further evaluation) _ 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.