# Kindergarten Registration Packet

**AM Kinder Classes will be chosen by a lottery process (8:30 – 12:10)**

☐ **PM Kinder class (10:50-2:30) preferred**

## Documents Required for Registration

*Completed and Signed Student Registration Form (LandTrack)
*Birth Certificate
*Current Shot Records (See below for requirements)
*Verification of Residence, preferably within 30 days of registration (See below for acceptable documents)

(1) Property tax payment receipts.
(2) Rental property contract, lease, or payment receipts.
(3) Utility service contract, statement, or payment receipts.
(4) Pay stubs.
(5) Voter registration.
(6) Correspondence from a government agency.
(7) Declaration of residency executed by the parent or legal guardian of a pupil.

Lodi Unified School District maintains a "No Shots, No School" policy. Shot requirements (In accordance with California Immunization Law AB 381)

| | | |
|---|---|---|
| Polio | 4 Doses | 3 doses are enough if at least 1 dose was given on or after the 4th birthday |
| DPT/DT/Td | 5 Doses | 4 doses are enough if 4th dose was given on or after the 4th birthday |
| Measles, Mumps, Rubella (MMR) | 2 Doses | 1 dose given on or after the 1st birthday; 2nd dose given prior to kindergarten |
| Hepatitis B | 3 Doses | 2nd dose given 1-2 months after 1st dose; 3rd dose given 6 months after 1st dose |
| Varicella (Chickenpox) | 2 Doses | Or required documentation of disease by health care provider of immunity. |

# LODI UNIFIED SCHOOL DISTRICT 2020/2021 NEW STUDENT REGISTRATION FORM

| FOR OFFICE USE ONLY |
|---|
| LUSD Student # _____ |
| SSID# _____ |
| Kindergarten [_] AM [_] PM |
| Charter [_] |
| Counselor/Teacher _____ |
| **Registration Date**_____ |

1. Today's Date _____/_____/_____ 2. Start Date _____/_____/_____

3. School Name _____

4. **First Date Enrolled in CA Public Schools** _____/_____/_____
***If this is your student's first enrollment in (K-12) CA Public Schools, please complete the Home Language Survey.***

5. Student previously enrolled in LodiUSD? ☐ Yes ☐ No 6. Incoming Grade Level _____

7. Student Name _____
Last First Middle Generation

Nickname (if applicable)_____

8. Physical Address_____
House No. Street Name Apt No. City Zip Code

Mailing Address_____
House No. Street Name Apt No. City Zip Code

9. Gender ☐ Male ☐ Female ☐ Nonbinary 10. Birth date _____/_____/_____

11.

| | Guardian 1 | Guardian 2 |
|---|---|---|
| Name | | |
| Relationship | | |
| Telephone | | |
| Email | | |
| Lives With | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Education Level | ☐ Non H.S. Graduate ☐ H.S. Graduate ☐ Some College (includes AA degree) ☐ College Graduate ☐ Graduate School ☐ Declined to State | ☐ Non H.S. Graduate ☐ H.S. Graduate ☐ Some College (includes AA degree) ☐ College Graduate ☐ Graduate School ☐ Declined to State |

12. Confidential Student Residence Information REQUIRED for Federal Reports. Please mark the appropriate residence types.

☐ Single family permanent residence (house, apartment, condo, mobile home) Mark if applicable: ☐ Group Home ☐ Foster Home

*If any of these are checked, please complete the **Intake Form**:*

☐ Motel or hotel

☐ Shelter or transitional housing program

☐ Doubled-up (sharing housing due to economic hardship or loss)

☐ Unsheltered (car/campsite)

☐ Other (please specify) _____

13. Other Children in the Family (Please list in order of birth)

| Name | Gender | Birth date | Relation to Student | Lives with? | School of Attendance |
|---|---|---|---|---|---|
| | | | | ☐ | |
| | | | | ☐ | |
| | | | | ☐ | |
| | | | | ☐ | |
| | | | | ☐ | |
| | | | | ☐ | |

# LODI UNIFIED SCHOOL DISTRICT 2020/2021 NEW STUDENT REGISTRATION FORM

14. Is your family involved in temporary or seasonal agricultural work? ☐ Yes ☐ No

15. Did your child attend preschool? ☐ Yes ☐ No If yes, name of preschool _____

16. Previous School Information

| Last school attended | Address |
|---|---|
| | |

| City & State | Zip | Phone | Has your child ever been retained? | In which grade? | Has your child ever been accelerated? | Has your child ever been expelled? |
|---|---|---|---|---|---|---|
| | | | ☐ Yes ☐ No | | ☐ Yes ☐ No | ☐ Yes ☐ No |

17. Previous Services Received (Select ALL that apply)

| | | | |
|---|---|---|---|
| ☐ Counseling | ☐ Gifted (G.A.T.E) | ☐ English Learner | ☐ 504 Plan |

18. Previous Special Education Services Received (Select ALL that apply)

| | | | |
|---|---|---|---|
| ☐ Speech | ☐ RSP | ☐ SDC | ☐ IEP |

19. Confidential Ethnic/Race Information for Federal/State reports. *Please answer to the best of your ability.*

**Part A. Is this student Hispanic or Latino? *(Select only one)***

☐ No, not Hispanic or Latino

☐ Yes, Hispanic or Latino – A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.

**Part B. Primary Race. Please identify the race(s) with which the student most closely identifies. Please identify the student's primary race by writing a "1" next to the race.** If applicable, you may identify up to four (4) additional races by writing a "2" next to the student's secondary race, a "3" next to the student's third race, a "4" next to the student's fourth race, and a "5" next to the student's fifth race.

___ AFRICAN AMERICAN OR BLACK

___ AMERICAN INDIAN OR ALASKA NATIVE
*(A person with origins from the original peoples of North, South and Central America, including the geographic regions covered by Canada, the United States, and Mexico.)*

ASIAN

___ Asian Indian ___ Cambodian ___ Chinese ___ Filipino ___ Hmong

___ Japanese ___ Korean ___ Laotian ___ Vietnamese ___ Other Asian

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

___ Guamanian ___ Hawaiian ___ Samoan ___ Tahitian ___ Other Pacific Islander

___ WHITE

20. I understand that due to overcrowded conditions at some schools in the Lodi Unified School District, there is a possibility that my child may be reassigned to another school during the school year, depending on the availability of classroom space. I understand that where the number of pupils enrolled appreciably increases, it may be necessary for my child to be reassigned during the school year.

_____
*Parent/Guardian Initials*

**21. I verify that all of the above information is accurate.**

_____
***Date*** ***Parent/Guardian Signature***

FOR OFFICE USE ONLY WHEN REGISTERING NEW STUDENTS
Residence verification

| Utility Bill | | Other: | | Checked by | |
|---|---|---|---|---|---|

# FORMULARIO DE MATRICULA 2020/2021 PARA ESTUDIANTES DEL DISTRITO ESCOLAR UNIFICADO DE LODI

**SÓLO PARA USO DE OFICINA**
LUSD Student # _____
SSID# _____
Country I.D. No._____
Kindergarten [_] AM [_] PM
Charter [_]
Counselor/Teacher _____

**Registration**
**Date**_____

1. Fecha de Hoy _____/_____/_____ 2. Fecha de Comienzo _____/_____/_____

3. Escuela _____

4. **Fecha de Primera Matricula en escuelas de CA** _____/_____/_____
***Si esta es la primera vez que su estudiante se matricula en una escuela de CA, complete la Encuesta de Lenguaje del Hogar.***

5. ¿Estudiante previamente matriculado en el distrito de Lodi? ☐ Si ☐ No 6. Grado de Ingreso _____

7. Nombre del Estudiante _____
Apellido Nombre Medio Generación

Apodo (si aplica) _____

8. Domicilio Físico _____
# de casa Nombre de Calle # de apartamento Ciudad Código postal

Dirección de Correo _____
# de casa Nombre de Calle # de apartamento Ciudad Código postal

9. Sexo ☐ Masculino ☐ Femenino ☐ No Binario 10. Fecha de Nacimiento _____/_____/_____

11.

| | Guardián legal 1 | Guardián legal 2 |
|---|---|---|
| Nombre | | |
| Relación | | |
| Teléfono | | |
| Correo Electrónico | | |
| ¿Vive con el Estudiante? | ☐ Si ☐ No | ☐ Si ☐ No |
| Nivel de Educación | ☐ No Graduado/a de la Escuela Preparatoria ☐ Graduado/a de la Universidad<br>☐ Graduado/a de la Escuela Preparatoria ☐ Escuela de Posgrado<br>☐ Alguna Universidad (incluye AA) ☐ Declina Declarar | ☐ No Graduado/a de la Escuela Preparatoria ☐ Graduado/a de la Universidad<br>☐ Graduado/a de la Escuela Preparatoria ☐ Escuela de Posgrado<br>☐ Alguna Universidad (incluye AA) ☐ Declina Declarar |

12. Información confidencial de residencia del estudiante REQUERIDA para informes Federales. Por favor marque las casillas apropiadas del tipo de residencia.

☐ Residencia permanente de una sola familia (casa, apartamento, condominio, casa móvil) Marque si aplica: ☐ Casa de Grupo ☐ Casa de Adopción

*Si alguno de estos está marcado, complete el* ***Formulario de Admisión****:*

☐ Motel o hotel (09)
☐ Programa de asilo o de alojamiento transitorio (10)
☐ Viviendo con otra familia (compartiendo casa debido a dificultad económica o perdida) (11)
☐ Sin hogar (carro/sitio para campar) (12)
☐ Otro (especificar) (15)_____

13. Otros niños en la familia (Por favor anótelos en orden de nacimiento)

| Nombre | Sexo | Fecha de Nacimiento | Relación al Estudiante | ¿Vive con? | Escuela a la que Asiste |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

# FORMULARIO DE MATRICULA 2020/2021 PARA ESTUDIANTES DEL DISTRITO ESCOLAR UNIFICADO DE LODI

14. ¿Trabaja su familia temporalmente en la agricultura? ☐ Si ☐ No

15. ¿Asistió su hijo(a) a preescolar? ☐ Si ☐ No Si sí, nombre del preescolar _____

16. Información de Escuela Anterior

| Ultima escuela a la que asistió su hijo/a | Dirección |
|---|---|
| | |

| Ciudad y Estado | Código Postal | Teléfono | ¿Ha sido su hijo/a retenido/a? | ¿En cuál grado? | ¿Ha sido su hijo/a acelerado al próximo grado? | ¿Ha sido su hijo/a expulsado/a? |
|---|---|---|---|---|---|---|
| | | | ☐ Si ☐ No | | ☐ Si ☐ No | ☐ Si ☐ No |

17. Servicios Recibidos Previamente (seleccione TODOS los que apliquen)

| | | | |
|---|---|---|---|
| ☐ Consejería | ☐ Dotado (G.A.T.E) | ☐ Estudiante Aprendiendo Ingles | ☐ Plan 504 |

18. Servicios de Educación Especial Recibidos Previamente (seleccione TODOS los que apliquen)

| | | | |
|---|---|---|---|
| ☐ Habla | ☐ RSP | ☐ SDC | ☐ IEP |

19. Información confidencial Étnica/ Racial requerida para informe Federal/Estatal. *Por favor conteste lo mejor que pueda.*

**Parte A. ¿Es el estudiante Hispano o Latino? *(Seleccione solo uno)***

☐ No, no Hispano o Latino

☐ Si, Hispano o Latino – Una persona de origen mexicano, puertorriqueño, cubano, sudamericano o centroamericano u otra cultura u origen español, no importando su raza.

**Parte B. Raza. Identifique la (s) raza (s) con las que el estudiante se identifica más de cerca. Identifique la raza primaria escribiendo un "1" junto a la raza.** Si aplica, puede identificar hasta cuatro (4) razas adicionales escribiendo un "2" junto a la segunda raza, un "3" junto a la tercera raza, un "4" junto a la cuarta raza, y un "5" junto a la quinta raza.

___ AFRO AMERICANO O NEGRO

___ INDIO AMERICANO O NATIVO DE ALASKA
*(Una persona con origen de la gente original del Norte, Sur y Centroamérica, incluidas las regiones geográficas cubiertas por Canadá, los Estados Unidos y México.)*

ASIATICO

| | | | | |
|---|---|---|---|---|
| ___ Indio Asiático | ___ Camboyano | ___ Chino | ___ Filipino | ___ Hmong |
| ___ Japonés | ___Coreano | ___ Laosiano | ___ Vietnamita | ___ Otro Asiático |

HAWAIANO NATIVO O NATIVO DE ALASKA

| | | | | |
|---|---|---|---|---|
| ___ Guamaniano | ___ Hawaiano | ___ Samoano | ___ Tahitiano | ___ Otro Isleño del Pacifico |

___ BLANCO

20. Entiendo que debido a condiciones de sobrepoblación en algunas escuelas en el Distrito Escolar Unificado de Lodi, existe la posibilidad de que mi hijo/a pueda ser reasignado a otra escuela durante el año escolar, dependiendo de la disponibilidad de espacio en el salón de clases. Entiendo que cuando el número de estudiantes matriculados aumenta apreciablemente, puede ser necesario reasignar a mi hijo/a durante el año escolar.

_____
*Iniciales de Padre/Guardián Legal*

**21. Yo verifico que toda la información anterior es correcta.**

_____
***Fecha*** ***Firma de Padre/Guardián Legal***

PARA USO DE OFICINA ÚNICAMENTE AL REGISTRAR NUEVOS ESTUDIANTES
Residence verification

| Utility Bill | | | Other: | | Checked by | |
|---|---|---|---|---|---|---|

Homeroom _____ Grade _____

# STUDENT EMERGENCY INFORMATION CARD

ONLY the adults listed on this emergency card will have authorization to have contact with the named student or permission to have the student released to them. *Please print clearly & carefully.*

Name _____ M☐ F☐ _____
Last First Middle Gender Primary Contact Phone

_____
Address (where student lives) City Zip Birthdate (Mo/Day/Yr) Student Cell Phone

Are any of this student's parents/guardians currently on active duty in any branch of the military? Yes☐ No☐

**Parent/Guardian Living With Student Relation** _____

Name _____

1st Phone _____ Home☐ Cell☐ Work☐

2nd Phone _____ Home☐ Cell☐ Work☐

3rd Phone _____ Home☐ Cell☐ Work☐

Mailing Address _____

Employer _____

Language of Correspondence _____

E-mail _____ Access to Student Info Online: Authorized☐ Not Authorized☐

**Parent/Guardian 2 Relation** _____ Live with Student?☐

Name _____

1st Phone _____ Home☐ Cell☐ Work☐

2nd Phone _____ Home☐ Cell☐ Work☐

3rd Phone _____ Home☐ Cell☐ Work☐

Mailing Address _____

Employer _____

Language of Correspondence _____

E-mail _____ Access to Student Info Online: Authorized☐ Not Authorized☐

Please check either Guardian or Emergency to signify Contact Type for the 3rd and 4th people to be called if the above cannot be reached in case of emergency

**#3 Guardian☐ Emergency☐ Live with Student?☐ Relation** _____

Name _____

1st Phone _____ Home☐ Cell☐ Work☐

2nd Phone _____ Home☐ Cell☐ Work☐

3rd Phone _____ Home☐ Cell☐ Work☐

Mailing Address _____

Employer _____

E-mail Access to Student Info Online: Authorized☐ Not Authorized☐

**#4 Guardian☐ Emergency☐ Live with Student?☐ Relation** _____

Name _____

1st Phone _____ Home☐ Cell☐ Work☐

2nd Phone _____ Home☐ Cell☐ Work☐

3rd Phone _____ Home☐ Cell☐ Work☐

Mailing Address _____

Employer _____

E-mail Access to Student Info Online: Authorized☐ Not Authorized☐

ADDITIONAL CONTACTS, NOT LISTED ABOVE, AUTHORIZED TO BE CALLED IN CASE OF EMERGENCY WHEN PARENT/GUARDIAN IS UNAVAILABLE:

(5) Name Primary Phone Second Phone Relationship

(6) Name Primary Phone Second Phone Relationship

WHEN PARENT/GUARDIAN/ALTERNATE IS UNAVAILABLE, I PERMIT THE SCHOOL TO TAKE THE ABOVE-NAMED STUDENT, AT MY PERSONAL EXPENSE, BY AMBULANCE, TO THE NEAREST HOSPITAL FOR TREATMENT TO:

Doctor Phone Address

Hospital Preference Insurance Provider / ID #

Please indicate any medical conditions that could or might result in an emergency situation:

☐PLEASE CHECK HERE IF THERE ARE **NO KNOWN** HEALTH PROBLEMS

☐Allergies (insect bites, food, medications, etc) ☐Asthma ☐Seizures ☐Diabetes ☐Hearing Impairment

☐Corrective Lenses ☐Neurological Disorders ☐Other _____

☐Other behavioral or mental health conditions: _____

☐Medications: _____

If necessary to dispense medication during school hours, a formal request signed by a doctor and parent must be completed and kept with the medication at school. A logged record is kept of such dispensing.

LAST NAME

FIRST NAME

I.D. NO.

PRIMARY CONTACT PHONE

Signature _____ Date _____

# LODI UNIFIED SCHOOL DISTRICT HOME LANGUAGE SURVEY

Name of Student: _____
(Last Name) (First Name) (Middle Name)

Age of Student: _____ Grade Level: _____

Directions to Parents and Guardians:

The California *Education Code* contains legal requirements which direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with these requirements. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered. If an error is made completing this home language survey, you may request correction before your student's English proficiency is assessed.

1. Which language did your child learn when he/she first began to talk? _____
2. Which language does your child most frequently speak at home? _____
3. Which language do you (the parents or guardians) most frequently use when speaking with your child? _____
4. Which language is most often spoken by adults in the home? (parents, guardians, grandparents, or any other adults) _____

Please sign and date this form in the spaces provided below, then return this form to the school office. Thank you for your cooperation.

_____ _____
Signature of Parent or Guardian Date

- **By signing this document, I confirm that the information provided above is accurate.**
- **Furthermore, I understand that if any one of questions 1, 2, or 3 have a language other than English, my child will be assessed for their English Language proficiency within 30 calendar days. INITIAL Identification only.**

**Distribution Instructions:**
Original –To be placed in cum file
Copy 1 – Parent
Copy 2 – If any items 1-3 have an answer other than English, place in green folder

# 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 | _____/_____/_____ |
| TB Risk Assessment and Test, if indicated | _____/_____/_____ |
| 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 (e.g., TB Test, if indicated) | | | | | |
| 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.dhcs.ca.gov/services/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, pidale al examinador de salud que llene este informe y entregelo a la escuela—este informe sera 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) | _____/_____/_____ |
| Evaluacion de Riesgo y prueba Tuberculosis* | _____/_____/_____ |
| 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 [acellular] 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 (e.g. prueba TB, de ser indicado) | | | | | |
| 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)

***de ser indicado**

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 _____

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.dhcs.ca.gov/services/chdp**

# 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:<br>□ Male □ Female |
| Parent/Guardian Name: | Child's race/ethnicity:<br>□ White □ Black/African American □ Hispanic/Latino □ Asian<br>□ Native American □ Multi-racial □ Other_____<br>□ 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)<br>□ Yes □ No | Visible Decay Present:<br>□ Yes □ No | Treatment Urgency:<br>□ No obvious problem found<br>□ Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation)<br>□ Urgent care needed (pain, infection, swelling or soft tissue lesions) |
|---|---|---|---|
| _____<br>***Licensed Dental Professional Signature*** | | _____<br>***CA License Number*** | _____<br>***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.*

# Oral Health Assessment Guidelines

Dear Parent or 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 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 service agency at (fill in appropriate local contact information, available at http://www.dhs.ca.gov/mcs/medi-Calhome/CountyListing1.htm.)

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 the Sacramento County Department of Health and Human Services Child Health and Disability Prevention Program at 916-875-7151.

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 Mary Ann Delleney, Coordinator, Health Programs 294-9013.