Loomis Union School District
3290 Humphrey Road, Loomis, CA 95650 (916) 652-1800
www.loomis-usd.k12.ca.us
Building Excellence in Education since 1856
Gordon T. Medd, Superintendent

Print Clear

Registration Checklist Kindergarten

Student Name _____ School _____

Date _____ Grade _____

Registration Checklist Kindergarten

√	Documents	Official Use Only
	Completed Registration Packet	
	Emergency Form/Annual Health Inventory	
	Registration Form	Special Services? Y/N
	Home Language Survey	
	Immunizations Records	
	CHDP-(Physical Form)	*4 yrs 3 months or older
	Health History	
	Dental Form (K or 1st grade)	
	Birth Certificate	
	*Proof of Residence	Intra? Or Inter?
	Intra: Resident School:	Requested School:

Loomis Union School District
3290 Humphrey Road, Loomis CA 95650
(916) 652-1800 (916) 652-1809 Fax

Emergency Card

If you are returning from the previous school year, has any information changed? ☐ Yes ☐ No
All students must return a completed emergency card to the school office annually.

Student Name_____Home Phone _____
(Last) (First)
M ☐ F ☐ Grade_____ Birth date_____

Street Address _____ Town_____ Zip _____

Mailing Address_____ Town_____ Zip _____

Father or Step Father Name (living in the home)_____

Work Phone_____ Cell Phone_____

E-mail _____

Mother or Step Mother Name (living in home)_____

Work Phone_____ Cell Phone_____

E-mail_____

Father or Mother Name (if ***NOT*** living in the home)_____

Work Phone_____ Cell Phone_____

Address:_____

E-mail_____

By providing my e-mail address above, I agree to receive pertinent information generated from the school and district offices.

If I cannot be reached in an emergency (accident, illness), I hereby grant permission for my child to be released from school to the contact person(s) listed below:

1) _____Phone_____ Relationship_____

2) _____Phone_____ Relationship_____

3) _____Phone_____ Relationship_____

After School Day Care Provider_____Phone_____

Is there a current legal agreement related to this student (i.e., custody agreement, restraining order)? If yes, please provide legal documents to the school office. ☐ Yes ☐ No

Family Physician_____ Phone_____

What action is to be taken if a complication is due to an allergic or health condition?_____

_____

In case of accident/emergency, *if parent or guardian cannot be reached,* I authorize a representative of the school to make such arrangements as he/she considers necessary for my child to receive medical or hospital care, including necessary transportation. I authorize such care and treatment to be performed by any licensed physician or surgeon.

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

Loomis Union School District
Annual Student Health Inventory

Returning Students fill out the form in full. Check "Yes", if new condition has occurred in the last year ☐**YES** ☐**NO**

New Students fill out the form in full. Initial any medical condition that pertains to the above named student. Attach a supplemental sheet to this form if you would like to provide more detailed information.

Initial	Condition description	Health code
_____	Asthma, reactive airway disease, exercise-induced asthma that requires **daily medication and/or an inhaler. Please specify (including) asthma triggers**_____	AS
_____	Diabetes, Type 1 or 11; wears insulin pump, uses glucometer **Please specify** _____	DM
_____	History of seizures, epilepsy, convulsions or treated with medication **Please specify date of last seizure**_____	S
_____	Significant allergic reaction (bees, peanuts, latex, etc.). **If uses Epi-pen, MD form req'd** **Please specify**_____	AL
_____	Learning disability (ADD, ADHD, dyslexia, etc.) that requires medication **Please specify** _____	LD
_____	Migraines or significant headaches that impact school performance **Please specify** _____	HA
_____	Medication request for school, including prescription or over-the-counter. **MD Form Req'd**	SM
_____	Orthopedic problems (scoliosis, arthritis, joint problems, cast/traction, etc.) **Please specify** _____	OR
_____	Heart condition (murmurs, pacemaker, valve disease, surgical history, etc.) **Please specify**_____	CV
_____	Significant recent illness/injury/surgery within the last 12 months (car accident, broken bone, Mononucleosis, Lyme disease, Whopping cough, Chicken pox, etc.) **Please specify** _____	HHx
_____	Medications taken at home on a daily basis, including vitamins and herbal supplements **Please specify** _____	HM
_____	Sensory deficit (hearing or visually impaired, hearing aids, glasses, contact lenses, etc.) **Please specify** _____	SEN
_____	Hepatitis A, B, or C, positive TB test, HIV, Meningitis or infectious disease **Please specify** _____	INF
_____	Depression, anxiety/panic disorder, schizophrenia, previous suicide attempts and/or on daily Mental health medications or treatment **Please specify** _____	MH

My signature indicates that I understand the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

Parent Signature_____Date_____

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For Office Use Only

Date Rec'd _____

Hm. School _____

Intra _____

Inter _____

Today's Date: _____

STUDENT REGISTRATION FORM

Child's LEGAL Name: _____ M☐ F☐ Grade: _____ DOB: _____

(Last) (First-Not Nickname) (Middle)

Age: _____ Child's Preferred Name (ALIAS) if different from legal name: _____

Parent/Guardian: _____ Phone: _____ Father's Work: _____Mother's Work: _____

Physical Address: _____

(House # & Street Name) (City) (State) (Zip)

Mailing Address **If Different:** _____

(House # & Street Name) (City) (State) (Zip)

Home Language – Which language is spoken most frequently in your home? (Check one) ☐English (00)

☐Chinese (201)	☐Portuguese (06)	☐Farsi (Persian) (16)
☐Spanish (01)	☐Japanese (08)	☐French (17)
☐Vietnamese (02)	☐Khmaf (Cambodian) (09)	☐German (18)
☐Cantonese (03)	☐Arabic (11)	☐Russian (29)
☐Korean (04)	☐Armenian (12)	☐American Sign Language (37)
☐Filipino (05)	☐Dutch (15)	☐Other (please specify): _____

Federal Race and Ethnicity Data Collection – Please complete part A & B

A. Is this student Hispanic or Latino? (Select only one) ☐No, not Hispanic or Latino ☐Yes, Hispanic or Latino?

B. What is this student's race? (Select one or more) You must check at least <u>one</u>: If more than one please check all that apply.

☐White (700) ☐ Black or African American (600) ☐American Indian or Alaskan Native (100)

<u>Asian – Specify (see below)</u>

☐Chinese (201)	☐Laotian (206)
☐Japanese (202)	☐Cambodian (207)
☐Korean (203)	☐Filipino (400)
☐Vietnamese (204)	☐Hmong (208)
☐Asian Indian (205)	☐Other Asian (299)

<u>Native Hawaiian or Other Pacific Islander (see below)</u>

☐Hawaiian (301)
☐Guamanian (302)
☐Samoan (303)
☐Tahitian (304)
☐Other Pacific Islander

Birthplace: City: _____ **State:** _____ **Country:** _____

If Country is other than US, please complete the following:

Arrival date in US: _____ Date of initial enrollment in a US School: _____ Date of enrollment in CA school: _____

If born outside the United States or U.S. Territories, was child born to United States military or United States diplomatic personnel? ☐Yes ☐No

The Loomis Union School District accepts all students, regardless of their birthplace and immigration status.

Parent Education Level- Please mark the education level of the most educated Parent

☐ Not a High School Graduate (1) ☐ High School Graduate (2) ☐ Some College (3)

☐ College Graduate (4) ☐ Graduate/Post Graduate Training (5)

Residence – Where is your child currently living?

This information is federally mandated by No Child Left Behind- Please check appropriate box/es.

☐ In a single family permanent residence-house, apartment, condominium, mobile home ☐ In or awaiting foster care placement

☐ With more than on family in a house or apartment ☐ In a motel, car or campsite

☐ With friends or other family members-other than parents, grandparents or legal caregiver ☐ In a group home

☐ In a shelter or transitional housing program

With whom does the student live: (Check all that apply)

☐ Father ☐ Mother ☐ Both ☐ Step-Father ☐ Step-Mother ☐ Foster/Group Home ☐ Other

Is the above checked person(s) the student's LEGAL guardian? ☐ YES ☐ NO If NO, please obtain a "Caregiver's Authorization Affidavit."

If Foster or Group Home, name of organization: _____Name of Case Worker: _____ Phone: _____

Contact Information

Check one: ☐ Father ☐ Step-Father ☐ Guardian Name: _____

Employer: _____ Occupation: _____ Work phone (with area code): _____

Cell #: _____ Email: _____

Check one: ☐ Mother ☐ Step-Mother ☐ Guardian Name: _____

Employer: _____ Occupation: _____ Work phone (with area code): _____

Cell #: _____ Email: _____

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

Full Name: _____ Address: _____ Phone: _____

Special Services

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

If YES, check type of program (s): ☐ Resource (RSP) ☐ Special Day (SDC) ☐ 504 Plan ☐ Speech/Language

☐ Hearing ☐ Vision ☐ GATE ☐ Occupational Therapy ☐ English Learner ☐ Other: _____

Is your child currently under an Expulsion Order from another school district? ☐ YES ☐ NO If YES, what district: _____

Student's last school of attendance: _____ Complete Address of School: _____

OTHER CHILDREN IN FAMLY ATTENDING LUSD SCHOOLS: (City) (State)

Name	Birth Date	Name	Birthdate

*I certify that the above information is correct and understood any incorrect information could compromise the enrollment of my student.

SIGNATURE OF PARENT/GUARDIAN:

_____**DATE:**_____

FOR OFFICIAL USE ONLY:

EVIDENCE OF BIRTH for First-Time TK/Kindergarten

- ☐ **Birth Certificate**
- ☐ **Baptismal Record**
- ☐ **Passport**
- ☐ **Affidavit**
- ☐ **Notice of Birth Registration**

Registration form Verified by (Registrar)_____

Verification of School residence: Street Address verified_____

Inter District Agreement verified_____

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HOME LANGUAGE SURVEY*

Student's Legal Name: _____ _____ _____
Last Name First Name Middle Name

School: _____ Date of Birth (Month/Day/Year): _____ Grade Level: _____

**A Home Language Survey (HLS) MUST ONLY be completed for NEWLY ENROLLED students in grades K-12. Parents or guardians who have previously completed a Home Language Survey do not need to complete this form a second time.*

Directions to Parents and Guardians:

The California Education Code requires schools to determine the language(s) spoken in the home of each student. If the Home Language Survey indicates a language other than English on the first three questions, or if it is believed through observation that the student speaks a language other than English, the student will be assessed for their English language proficiency.

For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered.

1. Which language did your child learn when he/she first began to talk? _____
2. Which language does your child most frequently use at home? _____
3. Which language do you use most frequently use to speak with your child? _____
4. Name the language(s) most often spoken by the adults at home? _____

Please sign and date this form in the spaces provided below. Thank you for your cooperation.

_____ _____
Signature of Parent or Guardian Date

For Office Use Only/ Solo para el uso de la escuela:
□*Yes* *Completed HLS recorded on Aeries Language page*
□*Yes* □*n/a* *EL Coordinator informed if a language other than English indicated*
□*Yes* *Completed HLS filed in cum*

State of California—Health and Human Services Agency

Department of Health Care 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.

PM 171 A (09/07) (Bilingual)

CHDP website: www.dhcs.ca.gov/services/chdp

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Health History
New Student Enrollment

Note: Your child's success in school depends to a great extent on his/her physical well-being. *Completion of this Health History form is optional, but the information obtained will help the School Nurse in identifying any health or educational needs of your child and will be kept confidential for school personnel use only.*

Student Name:	**Date of Birth:**

Names and ages of other children in family:

Name:	Age:
Name:	Age:
Name:	Age:

Are there any additional residents in the home? ☐ Yes ☐ No

If yes, please list and provide relationship to student:

Date of last physical examination:	Completed by:
Date of last dental examination:	Completed by:

Has your child had a professional eye exam? ☐ Yes ☐ No

If yes, Date of Last Exam:
Does your child wear glasses or contacts? ☐ Yes ☐ No
If yes, when should glasses be worn?

Birth History:

Pregnancy: (Any complications or abnormalities?)
Delivery: (Any complications or abnormalities?)
Condition at Birth: (Any complications or abnormalities?)

Developmental History:

Please provide the approximate age at which your child reached the following milestones:

Sat unassisted:	Walked:	Spoke First Words:
Spoke in Sentences:	Toilet Trained:	

Handedness: ☐ Right ☐ Left
Any challenges with: ☐ Thumbsucking ☐ Behavior ☐ Speech/Language
☐ Bowel or Bladder Control ☐ Other- Explain_____

(please complete reverse side)

Health History:

Has your child had any of the following? (Please check and describe)

☐ Serious Illness:	
☐ Serious Accidents:	
☐ Operations or Hospitalizations:	
☐ Head Injury	
☐ Ear Infections	
☐ Allergies	
☐ Frequent colds, minor illness	
☐ Seizures	
☐ Vision problems	☐ Hearing problems
☐ Speech Difficulties	☐ Learning Difficulties

Does your child take any medication on a regular basis? ☐ Yes ☐ No

If yes, please list: _____

Does your child have any limitations or special conditions to be watched at school?

☐ No ☐ Yes Explain:_____

Health Habits/Behavior:

Eating Habits: ☐ Good ☐ Fussy ☐ Poor
Food Allergies: ☐ No ☐ Yes Explain:
Sleep Habits: ☐ Sound Sleeper ☐ Restless ☐ Night Terrors
Number of Hours of Sleep per night:
Personality: ☐ Friendly ☐ Shy ☐ Aggressive ☐ Leader ☐ Follower
Behavior: ☐ Easy/Average ☐ Challenging ☐ Hard to Manage
Activity Level: ☐ Inactive ☐ Very Active ☐ Average
Play preference: ☐ With others ☐ With self ☐ Gets along with other children
Self care: ☐ Feeds self ☐ Dresses self ☐ Ties shoes

Are there any concerns (health, family, learning, etc.) the school staff should know?

Completed by:

Signature:	Date:

Thank you!

If you have any additional health concerns to share, please contact your School Nurse.

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Dear Parent or Guardian:

California law, Education Code Section 49452.8, now requires that your child have an oral health assessment (dental check-up) by June 15 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.

Please 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 for 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 www.dhcs.ca.gov.

2. Healthy Families' toll-free 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.

3. For additional resources that may be helpful, contact the local public health department.

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 les candy and sweet drinks, the better!

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

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

If you have questions about the new oral health assessment requirement, please contact the Loomis Union School District Office at 916-652-1800.

Sincerely,

Gordon T. Medd
Superintendent

Loomis Union School District

Oral Health Assessment/Waiver Request Form

California law, Education Code Section 49452.8, now requires that your child have an oral health assessment in kindergarten or first grade, whichever is his or her first year of public school. The law specifies that the assessment must be performed by a licensed dentist or other licensed or registered dental health professional. Oral health assessments that have happened within the 12 months before your child enters school also meet this requirement. If you cannot take your child for this assessment, you may be excused from this requirement by filling out Section 3 of this form.

Section 1
To be completed by the parent or guardian

Child's First Name:	Last Name:	Middle Initial:	Birthdate:
Address:			
City:		Zip Code:	
School Name:	Teacher:	Grade:	Child's Gender: ☐ Male ☐ Female
Parent/Guardian Name:			

Section 2
Oral Health Data Collection
To be completed by the dental professional conducting the assessment

Assessment Date:	Visible caries and/or fillings present: ☐ Yes ☐ No	Visible caries present: ☐ Yes ☐ No	Treatment Urgency: ☐ No obvious problem found ☐ Early dental care recommended ☐ Urgent care needed

Dental professional signature Date

Original to be retained in child's school record

Section 3

Waiver of Oral Health Assessment Requirement

To be completed by a parent or guardian requesting to be excused from the requirement

I request that my child be excused from the oral health assessment requirement for the following reason: (Please check the box that best describes the reason.)

☐ I am unable to find a dental office that will take my child's insurance plan
My child is covered by the following insurance plan:

☐ Medi-Cal/Denti-Cal ☐ Healthy Families ☐ Healthy Kids ☐ None

☐ Other: _____

☐ I cannot afford an oral health assessment for my child

☐ I do not wish my to receive an oral assessment

Optional: other reasons my child could not get an oral health assessment:

_____

_____

_____

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. If you have any questions about this requirement, please contact your school office.

Signature of parent or guardian Date