GILROY UNIFIED SCHOOL DISTRICT

7810 Arroyo Circle, Gilroy, California 95020
Tel. 669-205-4000 fax: 408-847-4717
www.gilroyunified.org

School Registration Requirements

1. Birth Verification (one required)
   - ☐ Certified Birth Certificate
   - ☐ Baptismal Certificate
   - ☐ Passport
   - ☐ Other _____
2. Complete Immunization Record – Including TB Test (PPD) requirements
3. Proof of Residency

This worksheet will assist you in the residence verification process. Please bring the **original** and a copy of one item from Box One and the **originals** and copies of two items from Box 2 to your attendance area school. If you do not have access to a copy machine, we will make copies for you. **The originals will be returned** the same day and copies will be turned in with your student registration packet.

Please direct any questions to the school secretary at your attendance area school.

Proof of residency from each category listed below: (total of 3 current forms required)

Category 1 (One form required)	Category 2 (Two forms required)
☐Mortgage Statement ☐Property Tax Statement ☐Escrow Papers ☐Rental Agreement	☐ PG&E Bill ☐ City of Gilroy Bill / Water Bill ☐ Waste / Recycling Bill ☐ Landline Phone Bill ☐ Cable Bill ☐ Homeowners / Renters Insurance declarations

YOU MUST BRING THE ORIGINAL DOCUMENTS FOR VERIFICATION

Any irregularities discovered during the residency verification process may result in further review by the GUSD Residence Verification Specialist.

GUSD

GILROY UNIFIED SCHOOL DISTRICT
STUDENT REGISTRATION

Dual Immersion ☐
PLEASE COMPLETE SEPARATE APPLICATION

Student Name:	Birthdate: Birthplace, State or Country	Male ☐ Female ☐ Other ☐
Last First Middle	MEDICAL PROBLEM: ☐YES ☐ NO	Grade level registering this year:
Mailing Address City Zip Code	LIST PROBLEM: (Attach any additional Information)	School Year:
Residence Address City Zip Code		

Primary Phone:	Emergency Contact- if responsible adult (parent, guardian) is unavailable Name Address Phone	Month/Year Moved To Current Address:
Has this student attended Gilroy Unified Schools in the past? ☐ Yes ☐ No School: _____ Grade: _____ Year: _____	List any siblings living in the home attending Gilroy Schools: ☐Yes ☐ No Name School/Grade _____ _____ _____	Has this student ever received any of the following services in this or any other District? GATE ☐ Yes ☐ No 504 ☐ Yes ☐ No Special Education* ☐ Yes ☐ No * (if yes identify services) Resource, Speech, Special Day

PLEASE FILL OUT MOBILITY FORM

Previous School (s) (List Pre-School if applicable)

Grades Attended	Date Enrolled	Date Left	School	Public Yes	Public No	State	City	County

Home Language Survey

If you answer any language other than English for any of the questions below, your child will be required to take an (ESL) (ELD) Test..

1. What language did this student learn when first beginning to talk? _____
2. What language do you use ***most frequently*** to speak to this student? _____
3. What language does this student ***most frequently*** use at home?
4. What is the preferred language for your correspondence?

Check all that Apply
☐ Mother
☐ Father
☐ Foster Parent
☐ Legal Guardian
☐ Other (Specify)

Divorced/Legally Separated ☐ Yes ☐ No
If Yes, Joint Custody? ☐ Yes ☐ No
☐ Emergency Contact?

Guardian Name: _____
_____
Address if different from student
Business Phone: _____ Ext. _____
Cell Phone: _____
Email: _____

Education Level, College Year or Degree Obtained:
☐ Not high school graduate ☐ College Graduate
☐ High School Graduate ☐ Graduate School
☐ Some College

Check all that Apply
☐ Mother
☐ Father
☐ Foster Parent
☐ Legal Guardian
☐ Other (Specify)

Divorced/Legally Separated ☐ Yes ☐ No
If Yes, Joint Custody? ☐ Yes ☐ No
☐ Emergency Contact?

Guardian Name: _____
_____
Address if different from student
Business Phone: _____ Ext. _____
Cell Phone: _____
Email: _____

Education Level, College Year or Degree Obtained:
☐ Not high school graduate ☐ College Graduate
☐ High School Graduate ☐ Graduate School
☐ Some College

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING IS TRUE AND THAT MY SUPPORTING DOCUMENTS ARE CORRECT.

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

Office Use Only

STUDENT ID:	SCH	REG-DATE	ENROLLED by	ETH	IMMUN	SPECIAL ED	HOME-SCH	Next School Code

	Documentation of Birthdate: ☐ Birth Certificate ☐ Passport ☐ Baptismal Certificate ☐ Military ID	Referred to ELD _____ ELD Status _____ Test Date _____	Primary Language ____	TRANSITIONAL KINDER ☐

Rev 01/20 PW

GILROY UNIFIED SCHOOL DISTRICT
Enrollment Center
7810 Arroyo Circle, Gilroy, California 95020
Tel. 669-205-4000 fax: 408-847-4717
www.gilroyunified.org

2020-2021
Mobility Form
(Confidential)

Student Information

Student's Name		Date of Birth	

Ethnicity / Race

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)

Mobility Information (Required/Mandated)

1. Circle the grade in which you are enrolling your child.	K 1 2 3 4 5 6 7 8 9 10 11 12	
2. Circle the grade when your child first entered/attended this district	K 1 2 3 4 5 6 7 8 9 10 11 12	
3. When did/will your child first attend school in the United States?	Month_____ Year_____	

GUS #127

GILROY UNIFIED SCHOOL DISTRICT

7810 Arroyo Circle
Gilroy, CA 95020
Telephone 669-205-4000 / Fax 408-842-1158

Student Name _____

According to Education Code Section 48915.1(b), it is the parents' responsibility to notify the receiving school district if their child has been expelled from another school district. This information is strictly confidential except as provided by education Code 49079: Confidential information to teacher.

(Check One)

_____ My child has never been expelled from a school district

_____ My child has been expelled from _____ school district in the past, but the term of expulsion has expired on _____. This information will be verified by the school district, which expelled your child.

_____ My child is currently expelled from _____ school district. The term of expulsion will expire on _____.

_____ My child is currently on probation
Probation Officer: _____ _____
Name Phone #

_____ _____
Parent/Guardian Signature Date

REVISED 3/7/2019

CALIFORNIA IMMUNIZATION REQUIREMENTS FOR

K – 12TH GRADE (including transitional kindergarten)

GRADE	NUMBER OF DOSES REQUIRED OF EACH IMMUNIZATION[1,2,3]				
K-12 Admission	4 Polio[4]	5 DTaP[5]	3 Hep B[6]	2 MMR[7]	2 Varicella
(7th-12th)[8]	K-12 doses	+ 1 Tdap			
7th Grade Advancement[9,10]		1 Tdap[8]			2 Varicella[10]

1. Requirements for K-12 admission also apply to transfer pupils.
2. Combination vaccines (e.g., MMRV) meet the requirements for individual component vaccines. Doses of DTP count towards the DTaP requirement.
3. Any vaccine administered four or fewer days prior to the minimum required age is valid.
4. Three doses of polio vaccine meet the requirement if one dose was given on or after the 4th birthday.
5. Four doses of DTaP meet the requirement if at least one dose was given on or after the 4th birthday. Three doses meet the requirement if at least one dose of Tdap, DTaP, or DTP vaccine was given on or after the 7th birthday (also meets the 7th-12th grade Tdap requirement. See fn. 8.)
6. For 7th grade admission, refer to Health and Safety Code section 120335, subdivision (c).
7. Two doses of measles, two doses of mumps, and one dose of rubella vaccine meet the requirement, separately or combined. Only doses administered on or after the 1st birthday meet the requirement.
8. For 7th-12th graders, at least one dose of pertussis-containing vaccine is required on or after the 7th birthday.
9. For children in ungraded schools, pupils 12 years and older are subject to the 7th grade advancement requirements.
10. The varicella requirement for seventh grade advancement expires after June 30, 2025.

One or two doses of Td vaccine given on or after the 7th birthday count towards the K-12 requirement.

DTaP/Tdap = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine
Hep B = hepatitis B vaccine
MMR = measles, mumps, and rubella vaccine
Varicella = chickenpox vaccine

INSTRUCTIONS:

California schools are required to check immunization records for all new student admissions at TK /Kindergarten through 12th grade and all students advancing to 7th grade before entry. Students entering 7th grade who had a personal beliefs exemption on file must meet the requirements for TK/K-12 and 7th grade. See shotsforschool.org for more information.

UNCONDITIONALLY ADMIT a pupil whose parent or guardian has provided documentation of any of the following for each immunization required for the pupil's age or grade as defined in table above:

- Receipt of immunization.
- A permanent medical exemption in accordance with 17 CCR section 6051.
- A personal beliefs exemption (filed in CA prior to 2016) in accordance with Health and Safety Code section 120335; this is valid until enrollment in the next grade span, typically at TK/K or 7th grade.

CONDITIONALLY ADMIT any pupil who lacks documentation for unconditional admission if the pupil has:

- Commenced receiving doses of all the vaccines required for the pupil's grade (table above) and is not currently due for any doses at the time of admission (as determined by intervals listed in Conditional Admission Schedule, column entitled "EXCLUDE IF NOT GIVEN BY"), or
- A temporary medical exemption from some or all required immunizations (17 CCR section 6050).

CONDITIONAL ADMISSION SCHEDULE FOR GRADES K-12

Before admission a child must obtain the first dose of each required vaccine and any subsequent doses that are due because the period of time allowed before exclusion has elapsed.

DOSE	EARLIEST DOSE MAY BE GIVEN	EXCLUDE IF NOT GIVEN BY
Polio #2	4 weeks after 1st dose	8 weeks after 1st dose
Polio #3	4 weeks after 2nd dose	12 months after 2nd dose
Polio #4[1]	6 months after 3rd dose	12 months after 3rd dose
DTaP #2	4 weeks after 1st dose	8 weeks after 1st dose
DTaP #3[2]	4 weeks after 2nd dose	8 weeks after 2nd dose
DTaP #4	6 months after 3rd dose	12 months after 3rd dose
DTaP #5	6 months after 4th dose	12 months after 4th dose
Hep B #2	4 weeks after 1st dose	8 weeks after 1st dose
Hep B #3	8 weeks after 2nd dose	12 months after 2nd dose and at least 4 months after 1st dose
MMR #2	4 weeks after 1st dose	4 months after 1st dose
Varicella #2	Age less than 13 years: 3 months after 1st dose	4 months after 1st dose
	Age 13 years and older: 4 weeks after 1st dose	8 weeks after 1st dose

1. Three doses of polio vaccine meet the requirement if one dose was given on or after the fourth birthday.
2. If DTaP #3 is the final required dose, DTaP #3 should be given at least six months after DTaP #2, and pupils should be excluded if not given by 12 months after second dose. Three doses meet the requirement if at least one dose of Tdap, DTaP, or DTP vaccine was given on or after the seventh birthday. One or two doses of Td vaccine given on or after the seventh birthday count towards the requirement.

Continued attendance after conditional admission is contingent upon documentation of receipt of the remaining required immunizations. The school shall:

- review records of any pupil admitted conditionally to a school at least every 30 days from the date of admission,
- inform the parent or guardian of the remaining required vaccine doses until all required immunizations are received or an exemption is filed, and
- update the immunization information in the pupil's record.

For a pupil **transferring** from another school in the United States whose immunization record has not been received by the new school at the time of admission, the school may admit the child for up to 30 school days. If the immunization record has not been received at the end of this period, the school shall exclude the pupil until the parent or guardian provides documentation of compliance with the requirements.

Questions?

See the California Immunization Handbook at ShotsForSchool.org

Tuberculosis (TB) and Latent TB Infection FACT SHEET

Santa Clara County PUBLIC HEALTH

What is TB?

Tuberculosis (TB) is a disease caused by a bacteria that is spread through the air from person to person. Although TB most often affects the lungs, it can affect any part of the body including lymph nodes, bones, kidneys, and the brain. TB can cause very severe illness and it can be fatal. Fortunately, TB can be prevented, treated, and cured!

What Are the Symptoms of TB?

Symptoms of TB can include fever, weight loss, night sweats, and fatigue. When TB affects the lungs, symptoms can also include a cough that lasts more than 2-3 weeks, coughing up blood, and chest pain. If you have any of these symptoms you need to see a doctor!

Is TB a problem in Santa Clara County (SCC)?

Yes. SCC has the fourth highest number of TB cases among all counties in California, after Los Angeles, San Diego, and Orange counties. The rate of TB in SCC is over 3 times as high as the national rate. It is estimated that 8.5% of SCC residents have latent TB infection, though most do not know they are infected.

Who Does TB Affect in Santa Clara County?

TB can infect anyone who lives, works, or breathes in close proximity to someone with infectious TB disease, regardless of their age, race, sex, or socioeconomic status. Over 90% of patients with TB disease in SCC were born outside of the U.S., though most have lived in the U.S. for more than 5 years. In SCC, the majority of cases occur among people born in Vietnam, the Philippines, India, and China.

How Do You Get TB Infection?

The bacteria that causes TB is spread through the air from person to person when an individual with TB disease of the lungs or throat coughs, sneezes, or speaks. When people nearby breathe in the bacteria they may become infected, particularly if they are in close or prolonged contact. When someone has been infected, but they do not yet have symptoms or evidence of TB disease, this is called latent tuberculosis infection (LTBI).

What is the Difference Between Latent TB Infection (LTBI) and TB Disease?

When someone has been infected with the bacteria that causes TB, as long as their body is able to prevent the bacteria from growing, they will have no symptoms or evidence of TB disease. This is called latent tuberculosis infection (LTBI), which is not contagious to other people.

When your body can no longer prevent the bacteria from growing, the bacteria multiply and cause you to become sick with TB disease. People with LTBI may develop TB disease within weeks to many years after becoming infected. People with TB disease are usually sick and may be able to spread the bacteria to others if TB affects their lungs or throat. The risk of developing TB disease is highest among persons with weakened immune systems.

You Should Get Tested for Latent TB Infection (LTBI) if You...

- Were in close or prolonged contact with someone with TB of the lungs or throat.
- Were born in a country with an elevated TB rate (i.e. countries other than the U.S., Canada, Australia, New Zealand, or Western and Northern European countries).
- Have a condition that is associated with a higher risk of TB including HIV; diabetes; end stage renal disease; head, neck, or lung cancer; leukemia; lymphoma; silicosis; have a history of gastrectomy or jejunoileal bypass; or are significantly underweight.
- Take drugs that weaken your immune system (e.g. chemotherapy, anti-rejection drugs after organ transplant, TNF-alpha inhibitors, oral steroids equal to 15 mg of prednisone or more for at least one month).
- Have injected illegal drugs.
- Smoke.
- Have worked or stayed in a homeless shelter, correctional facility (e.g. prison or jail) or other group setting.

How Can I Tell if I Have Latent TB Infection (LTBI)?

A TB blood test (e.g. Quantiferon or T-spot) or TB skin test (TST or PPD) can be performed to find out if you have TB bacteria in your body.

A "positive" test result means you probably have TB bacteria in your body. Most people with a positive TB blood test or TB skin test have latent TB infection. To be sure that you do not have TB disease, your doctor will examine you and perform a chest x-ray. You may also need other tests to see if you have latent TB infection or TB disease.

What if I've Had the BCG vaccine?

A positive TB skin test should never be ignored. BCG vaccines (TB vaccines) are given in countries where TB is common. BCG vaccines may help protect young children from getting very sick with TB. However, this protection goes away as people get older. People who have had a BCG vaccine can still get latent TB infection and TB disease.

If you had the BCG vaccine, you can be tested with either a TB blood test or a TB skin test. If you have a choice, a TB blood test is best because the TB blood test is not affected by BCG vaccines. This means that your TB blood test will be "positive" only if you have TB bacteria in your body.

What is the Treatment for Latent TB Infection (LTBI)?

LTBI can be treated with medicine to prevent developing TB disease. Treatment options include:

- Isoniazid and Rifapentine once weekly for 12 weeks
- Rifampin daily for 4 months
- Isoniazid daily for 9 months

Ask your doctor which treatment is best for you.

Why Should I Take Medicine if I Don't Feel Sick?

If you have latent TB infection (LTBI), this means that you have TB bacteria living in your body, even though you are not sick. You may develop TB disease if you do not take medicine to treat LTBI. Treatment can decrease the risk of developing TB disease by over 90% when medications are taken as prescribed. It is important that you finish your medicine so that the treatment is effective and so that you do not develop drug resistance. ***For more information on TB, visit www.sccphd.org/tbinfo or contact Santa Clara County Public Health Department.***

Child's Name: _____ **Birthdate:** _____ **Male/Female** **School:** _____
Last, First month/day/year

Address _____ **Phone:** _____ **Grade:** _____
Street City Zip

Santa Clara County Public Health Department
Tuberculosis (TB) Risk Assessment for School Entry

This form must be completed by a U.S. licensed primary care provider and returned to the child's school.

1. Was your child born in, or has your child resided in or traveled to (for more than one week) a country with an elevated TB rate?*	☐ Yes	☐ No
2. Has your child been exposed to anyone with TB disease?	☐ Yes	☐ No
3. Has a family member had a positive TB test or received medications for TB?	☐ Yes	☐ No
4. Was a parent, household member, or visitor who stayed in the child's home for >1 week, born in a country with an elevated TB rate?*	☐ Yes	☐ No
5. Is your child immunosuppressed [e.g. due to HIV infection, organ transplant, treatment with TNF-alpha inhibitor or high-dose systemic steroids (e.g. prednisone ≥ 15 mg/day for ≥ 2 weeks)].	☐ Yes	☐ No

*Most countries other than the U.S., Canada, Australia, New Zealand, or a country in western or northern Europe. This does not include tourist travel for <1 month (i.e. travel that does not involve visiting family or friends, or involve significant contact with the local population).

If YES, to any of the above questions, the child has an increased risk of TB and should have a TB blood test (IGRA, i.e. QuantiFERON or T-SPOT.TB) or a tuberculin skin test (TST) unless there is either 1) a documented prior positive IGRA or TST performed in the U.S. or 2) no new risk factors since last documented negative IGRA (performed at age ≥2 years in the U.S.) or TST (performed at age ≥6 months in the U.S.).

All children with a current or prior positive IGRA/TST result must have a medical evaluation, including a chest x-ray (CXR; posterior-anterior and lateral for children <5 years old is recommended). CXR is not required for children with documented prior treatment for TB disease, documented prior treatment for latent TB infection, or BCG-vaccinated children who have a positive TST and negative IGRA. If there are no symptoms or signs of TB disease and the CXR is normal, the child should be treated for latent TB infection (LTBI) to prevent progression to TB disease.

Enter test results for all children with a positive risk assessment:

Interferon Gamma Release Assay (IGRA) Date:	Result: ☐ Negative ☐ Positive ☐ Indeterminate
Tuberculin Skin Test (TST/Mantoux/PPD) Date placed: Date read:	Induration _____ mm Result: ☐ Negative ☐ Positive
Chest X-Ray Date: _____	Impression: ☐ Normal ☐ Abnormal
LTBI Treatment Start Date: _____ ☐ Rifampin daily - 4 months ☐ Isoniazid/rifapentine - weekly X 12 weeks ☐ Isoniazid daily - 9 months ☐ Other: _____	☐ Prior TB/LTBI treatment (Rx & duration): _____ ☐ Treatment medically contraindicated: _____ ☐ Declined against medical advice

Please check one of the boxes below and sign:

☐ Child has no TB symptoms, no risk factors for TB, and does not require a TB test.
☐ Child has a risk factor, has been evaluated for TB and is free of active TB disease.
☐ Child has no new risk factors since last negative IGRA/TST and no TB symptoms.

_____ _____
Health Care Provider Signature, Title Date

Name/Title of Health Provider:
Facility/Address:
Phone number:

County of Santa Clara
Public Health Department

Tuberculosis Prevention & Control Program
976 Lenzen Avenue, Suite 1700
San José, CA 95126
408.885.2440

Testing Methods

An Interferon Gamma Release Assay (IGRA, i.e. QuantiFERON or T-SPOT.TB) or Mantoux tuberculin skin test (TST) should be used to test those at increased risk. An IGRA can be used in all children ≥ 2 years old and is preferred in BCG-vaccinated children to avoid a false positive TST result. A TST of ≥10mm induration is considered positive. If a child has had contact with someone with active TB disease (yes to question 2 on reverse), or the child is immunosuppressed, then TST ≥5 mm is considered positive. If a BCG-vaccinated child has a positive TST, and an IGRA is subsequently performed and is negative, testing is considered negative unless the child was exposed to someone with TB disease or is immunosuppressed. For immunosuppressed children, screening should be performed by CXR in addition to a TST/IGRA (consider doing both) and symptom review.

Evaluation of Children with Positive TB Tests

- All children with a positive IGRA/TST result must have a medical evaluation, including a CXR (posterior-anterior and lateral is recommended for children <5 years old). A CXR is not required for a positive TST with negative IGRA in a BCG-vaccinated child, or if the child has documentation of prior treatment for TB disease or treatment for latent TB infection.
- For children with TB symptoms (e.g. cough for >2-3 weeks, shortness of breath, hemoptysis, fever, weight loss, night sweats) or an abnormal CXR consistent with active TB disease, report to the County of Santa Clara Public Health Department TB Program within one day. The child will need to be evaluated for TB disease with sputum AFB smears/cultures and nucleic acid amplification testing. A negative TST or IGRA does not rule out active TB disease in a patient with symptoms or signs of TB disease. The child cannot enter school unless active TB disease has been excluded or treatment has been initiated.
- If there are no symptoms or signs of TB disease and the CXR is normal, the child should be treated for latent TB infection (LTBI). Do not treat for LTBI until active TB disease has been excluded.
- Short-course regimens (rifampin daily for four months or 12-dose weekly isoniazid/rifapentine) are preferred (except in persons for whom there is a contraindication, such as a drug interaction or contact to a person with drug-resistant TB) due to similar efficacy and higher treatment completion rates as compared with 9 months of daily isoniazid

Treatment Regimens for Latent TB Infection

- Rifampin 15 - 20 mg/kg (max. 600 mg) daily for 4 months
- 12-dose Weekly Isoniazid/Rifapentine (3HP) Regimen:
  - Isoniazid
    2-11 years old: 25 mg/kg rounded up to nearest 50 or 100 mg (max. 900 mg)
    ≥ 12 years old: 15 mg/kg rounded up to nearest 50 or 100 mg (max. 900 mg)
  - Rifapentine
    10.0-14.0 kg: 300 mg
    14.1-25.0 kg: 450 mg
    25.1-32.0 kg: 600 mg
    32.1-50.0 kg: 750 mg
    >50 kg: 900 mg
  - Vitamin B6 50 mg weekly
- Isoniazid 10 mg/kg (range, 10-15 mg/kg; max. 300 mg) daily for 9 months. Recommended pyridoxine dosage is 25 mg for school-aged children (or 1-2 mg/kg/day).

For additional information: www.sccphd.org/tb or contact the TB Control Program at (408) 885-2440.

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31 of his/her first year in public school. A California licensed dental professional operating within his scope of practice must perform the check-up and fill out Section 2 of this form. If your child had a dental check-up in the 12 months before he/she started school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Sex: ☐ Male ☐ Female
Parent/Guardian Name:	Child's race/ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Multi-racial ☐ Other_____ ☐ Native Hawaiian/Pacific Islander ☐ Unknown		

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

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

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.

Formulario de Evaluación de Salud Dental

La ley de California (Sección 49452.8 del Código de Educación) estipula que su hijo(a) tenga un examen dental a más tardar el 31 de mayo de su primer año en escuela pública. Un profesional de salud dental licenciado por el estado de California y operando dentro del alcance de su práctica debe hacer el examen y completar la Sección 2 de éste formulario. Si su hijo(a) ha tenido un examen dental en los 12 meses antes de comenzar la escuela, pídale a su dentista que llene la Sección 2 del formulario. Si no le es posible llevar a su hijo(a) a hacerle el examen dental, llene la Sección 3.

Sección 1: Información del Estudiante (Completado por el padre o tutor)

Primer Nombre del Niño(a):	Apellido:	Inicial:	Fecha de Nacimiento:
Dirección:			Unidad:
Ciudad:			Código Postal:
Nombre de la Escuela:	Maestro(a):	Grado:	Sexo: ◻ Masculino ◻ Femenino
Nombre del Padre o Tutor:	Raza u Origen Étnico del(a) Niño(a): ◻ Blanco ◻ Negro/Afro Americano ◻ Hispano/Latino ◻ Asiático ◻ Indio Americano ◻ Multirracial ◻ Otro_____ ◻ Hawaiano/Isleño Pacífico ◻ Desconocido		

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

(Información de Salud Dental – completada por el profesional de salud dental)

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

Assessment Date: *(fecha de evaluación)*	Caries Experience (Visible decay and/or fillings present) *(caries visibles y/o empastes presentes)* ◻ Yes *(sí)* ◻ No *(no)*	Visible Decay Present: *(caries visibles presentes)* ◻ Yes *(sí)* ◻ No *(no)*	Treatment Urgency *(urgencia de tratamiento)*: ◻ No obvious problem found *(no se encuentra ningún problema obvio)* ◻ Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) *(se recomienda atención dental; caries sin dolor o infección, el niño se beneficiaría de sellador o evaluación adicional)* ◻ Urgent care needed (pain, infection, swelling or soft tissue lesions) *(se necesita atención urgente; dolor, infección, hinchazón, lesiones)*

_____	_____	_____
Licensed Dental Professional Signature *(Firma del Profesional de Salud Dental)*	***CA License Number*** *(Número de Licencia de California)*	***Date*** *(Fecha)*

Sección 3: Exoneración del Requisito de Evaluación de Salud Dental

A ser completado por el padre o tutor quien solicita ser exonerado de éste requisito

Por favor excuse a mi hijo(a) de tener el examen dental ya que: (Marque el encasillado que mejor describa la razón)

◻ No he podido encontrar una oficina dental que acepte el plan de seguro de mi hijo(a).
El plan de seguro dental de mi hijo(a) es:
◻ Medi-Cal/Denti-Cal ◻ Healthy Families ◻ Healthy Kids ◻ Otro _____ ◻ Ninguno

◻ No puedo pagar por el examen dental de mi hijo(a).

◻ No deseo que mi hijo(a) reciba un examen dental.

Opcional: otra razón por la cual mi hijo(a) no pudo tener un examen dental: _____

Si quiere ser excusado de éste requisito: ▶ _____
Firma del padre o tutor ***Fecha***

La ley estipula que las escuelas deberán mantener privada la información de salud de los estudiantes. El nombre de su hijo(a) no se utilizará en ningún reporte hecho a consecuencia de dicha ley. Esta información solo se utilizará para propósitos relacionados con la salud de su hijo(a). Si tiene alguna pregunta, por favor comuníquese con su escuela.

Devuelva éste formulario a la escuela a más tardar el 31 de mayo del primer año escolar de su hijo(a).
El original será guardado en el registro escolar del estudiante.

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	/ /
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.

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, pídale al examinador de salud que llene este informe y entregelo a la escuela—este informe será 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