___ **Kindergarten** enrollment
___ **Transitional Kindergarten** enrollment

TRANSITIONAL KINDER (TK) / KINDERGARTEN REGISTRATION 2022-2023

On March 1, 2022, Oak Grove School District will begin registration of children who will enter transitional kindergarten (TK) and kindergarten in August 2022. Children born on or before September 1, 2017 may enroll in our kindergarten program. **CHILDREN BORN BETWEEN SEPTEMBER 2, 2017 AND FEBRUARY 2, 2018 MAY ENROLL IN OAK GROVE SCHOOL DISTRICT'S TRANSITIONAL KINDERGARTEN PROGRAM.**

PARENTS/GUARDIANS ARE REQUIRED TO PROVIDE THE FOLLOWING INFORMATION AT THE TIME OF REGISTRATION. (Please use this letter as a checklist as you gather the information.)

___ 1. **Verification of Age** (one of the following):
   a. Certified copy of a birth record
   b. Original county recorder's verification of birth (hospital forms will not be accepted)
   c. Passport
   d. Baptism Certificate
   e. Affidavit of the parent, guardian, or custodian, or any other mans of providing the child's age

___ 2. **Verification of Address** (one of the following):
   a. Utility bill (home phone, electricity, water, etc.)
   b. Rental agreement/lease
   c. Property tax payment receipts
   d. Pay stub
   e. Voter registration
   f. Correspondence from a government agency
   g. Declaration of residency executed by the parent or legal guardian of the student

___ 3. **Doctor's verification of month and year of the following immunizations:**
   ___ a. **Polio (4 doses)** 3 doses meet the requirement if one dose was given on or after the 4th birthday.
      - OPV or IPV
   ___ b. **DTaP (5 doses)** 4 doses meet the requirement if at least one dose was given on or after the 4th birthday.
      - Diphtheria
      - Tetanus
      - Pertussis
   ___ c. **MMR (2 doses)** Both doses must be given on or after the 1st birthday.
      - Measles
      - Mumps
      - Rubella
   ___ d. **Hepatitis B (3 doses)**
   ___ e. **Varicella (2 doses)**

___ 4. **Santa Clara County Public Health Department TB Risk Assessment for School Entry Form**
Completed by child's pediatrician within 12 months prior to school registration.

___ 5. **Full physical examination (completed after March 1, 2022).**

___ 6. **Dental examination** (completed within 12 months prior to Kindergarten)

NOTE: STATE LAW REQUIRES that each child have a full health examination within 18 months prior to entering first grade. District guidelines require that your child receive a full physical examination no earlier than six months before starting kindergarten (after **March 1, 2022**). A doctor's report form has been included with the registration materials. Most physicians prefer to do the physical exam when updating the immunizations.

Kindergarten registration will begin on March 1, 2022. For more information, please contact your Home School Office or visit our website at https://www.ogsd.net/

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.

OAK GROVE SCHOOL DISTRICT

6578 Santa Teresa Boulevard, San Jose, CA 95119, Phone: (408) 227-8300, Fax: (408) 225-3548

Dear Parent or Guardian:

To make sure your child is ready for school, California law now requires that your child have a dental check-up for kindergarten or first grade, whichever is his/her first year of public school. Oak Grove School District requires this examination ***prior*** to kindergarten entry. Check-ups that have happened within the 12 months before your child enters school meet this requirement. The law specifies that the assessment must be done by a licensed dentist or other licensed or registered dental health professional.

Take the attached Oral Health Assessment 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 complete Section 3: Waiver of Oral Health Assessment Requirement on the attached Oral Health Assessment Form.

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 ***(1-800-322-6384)*** or website ***(www.denti-cal.ca.gov)*** can help you find a dentist who takes Denti-Cal.

2. Healthy Families' toll-free number ***(1-800-880-5305)*** or website ***(http://www.benefitscal.com/)*** can help you find a dentist who takes Healthy Families insurance.

3. Healthy Kids is another low-cost insurance program your child may qualify for. To find out if your child can enroll in any of the above programs or Healthy Kids, call toll-free number ***1-800-821-5437.***

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 cause cavities and replace 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 any questions about this dental requirement, please contact our District Nurse at 408-227-8300 ext. 100278.

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.

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.

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 licensed health professional in the U.S. and returned to the child's school.

1. Was your child born in, resided, or traveled (for more than one month) to a country with an elevated rate of TB*? ☐ Yes ☐ No
2. Has your child been in close contact to anyone with tuberculosis (TB) disease in their lifetime? ☐ Yes ☐ No
3. Is your child immunosuppressed; current, or planned? (e.g., due to HIV infection, organ transplant, treatment with TNF-alpha antagonist 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 has no symptoms.
☐

_____ _____
Health Care Provider Signature, Title Date

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

OAK GROVE SCHOOL DISTRICT

CONFIDENTIAL HEALTH HISTORY FORM

School_____

Student Name _____ ☐ **Male** ☐**Female** **Birthdate** _____**Age**____ **Grade**_____

☐ *My child **does not** have any health issues at this time.*

If your child has health issues, please answer the following questions:

Does your child take medication on a routine basis? ☐ Yes ☐ No ☐ During school hours? ☐Yes ☐ No If yes,

Name of medication _____ Name of medication _____

Name of medication _____ Name of medication_____

If your child must take prescriptions or over the counter medications during the school day, complete the Medication Administration parent/physician authorization form and return to the school office, (One form for each medication).

Check ☑ the box and explain if your child has a history of or now has the following conditions or concerns.

☐ **Asthma** ☐ Mild ☐ Moderate ☐ Severe
☐ Inhaler at home ☐ Inhaler at school office

☐ **Seizures** ☐ As an infant only
☐ Currently takes medication
_____

☐ **Physical Limitations** _____
☐ Special Equipment needed at home
☐ Special Equipment needed at school

☐ **Allergies** ☐Mild ☐ Moderate ☐ Severe
☐ Bees/insects
☐ Foods _____
☐ Seasonal Hay fever
☐ Allergic to Medication _____
☐ Other _____
☐ EpiPen at home ☐ EpiPen at school

☐ **Heart Murmur/Disease** _____

☐ **Other Conditions** _____

☐ **Diabetes** ☐ **Type I** ☐ **Type II**

- Has your child been hospitalized for diabetes? ☐ Yes ☐ No
  If yes, give date and explain hospital course: _____
- Can your child monitor his/her blood glucose level independently? ☐ Yes ☐ No
- Can your child tell if he/she is having symptoms of high or low blood glucose levels? ☐ Yes ☐ No
  If yes, what are his/her symptoms? _____
- Has Glucagon ever been given to your child? ☐ Yes ☐ No Last given: _____

Is your child *currently* under a doctor's care for any of the above? ☐ Yes ☐ No
If yes: Doctor's name _____**Phone** _____**Fax**_____

Address_____

☐ **I hereby give permission to share information pertaining to the health of my child with school staff who need to know.**

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

For Office Use Only:
☐ Doctor's orders completed including parent and physician signatures.
☐ Diabetic Supplies
☐ Snacks
☐ Signed *Diabetic Orders for School* indicating parent review

☐ Original to Cum ☐Faxed to District Nurse 408-225-3752 ☐ *Health Assistant* ☐ Teacher

OAK GROVE SCHOOL DISTRICT

6578 Santa Teresa Boulevard, San Jose, CA 95119, Phone: (408) 227-8300, Fax: (408) 629-7183

Student's Name _____ Teacher _____

EMERGENCY INFORMATION *(This will be used if the Emergency Card is not available)*
If I cannot be reached, I authorize the school to contact the person listed below. I further authorize the school to release the student to the person listed below.

Name: _____ Phone: _____

I also give my consent for emergency medical or dental treatment, including transportation to the nearest emergency aid facility, if I or the person listed above cannot be reached.

Signature of Parent/Legal Guardian _____ Date _____

INFORMACION DE EMERGENCIA (Esta información será usada si la Tarjeta de Emergencia no está disponible.)
Si no pueden comunicarse conmigo, autorizo que la escuela se comunique con la persona cuyo nombre aparece abajo. Además, autorizo a la escuela a entregar al/a estudiante a la persona anotada abajo.

_____ _____
Nombre Teléfono

También doy mi permiso para que mi hijo(a) reciba tratamiento médico o dental incluyendo transportación al lugar médico más cercano si no se pueden poner en contacto conmigo o con la persona cuyo nombre aparece anotado arriba.

_____ _____
Firma del padre/Tutor legal Fecha

CHI TIẾT VỀ SỰ KHẨN CẤP LIÊN QUAN ĐẾN EM HỌC SINH (Chi tiết này sẽ được dùng nếu không có Thẻ Khẩn Cấp)
Trong trường hợp nhà trường không liên lạc được với chúng tôi, chúng tôi cho phép nhà trường liên lạc với người có tên dưới đây. Ngoài ra, chúng tôi cũng cho phép nhà trường được quyền trao con em tôi cho người có tên dưới đây.

_____ _____
Tên Điện thoại

Chúng tôi cũng đồng ý cho nhà trường mang con em tôi đến phòng cấp cứu gần nhất để chữa bệnh hay chữa răng nếu nhà trường không liên lạc được với người có tên nêu trên.

_____ _____
Chữ ký của Phụ Huynh/Giám Hộ Ngày

Attachment to forms 2339, 2347, 2348