REGISTRATION CHECK LIST

- ☐ Enrollment Form
- ☐ Student Attendance & Behavioral Agreement
- ☐ Physical Exam
- ☐ Oral Health Assessment
- ☐ Immunization Records
- ☐ Birth Certificate
- ☐ Social Security Card
- ☐ Proof of Residency (PG&E Bill or Water Bill)

Mustang reminder:

Please let the front office know if your son/daughter need any of the following forms:

- Medication taken during school hours
- Medical Statement to request special meals and/or accommodations

GRADE

Maple Elementary School District Student Registration

Student Last Name:

First Name:

Permanent ID:

▶ **Has your student ever attended Maple Elementary public schools before?** ☐ Yes ☐ No School attended: _____ Year attended: _____

PLEASE PRINT – STUDENT'S LEGAL NAME

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

☐ Male ☐ Female | Birth date: Month / Day / Year

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

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

Mailing Address	Apt#	City	State	Zip

Residence Address (house # & street name if different)	Apt #	City	State	Zip

WHAT IS YOUR CHILD'S ETHNICITY? (Please check one)

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

☐ Not Hispanic or Latino

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

The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be.

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

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

☐ Graduate Degree or Higher (5)
☐ College Graduate (4)
☐ Some College or Associate's Degree (3)
☐ High School Graduate (2)
☐ Not a High School Graduate (1)

Date student first attended school in the U.S.

Month	Day	Year

Date student first attended school in California

Month	Day	Year

BIRTHPLACE: City: _____ State: _____ Country: _____

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THE FORM (REV 6/17)

HOME LANGUAGE SURVEY: Indicate only one language (most frequently used) per line:

1. What language/dialect does your son/daughter most frequently use at home? _____
2. Which language/dialect did your son/daughter learn when he/she first began to talk? _____
3. What language/dialect do you most frequently speak to your child? _____
4. Has your child ever been given the CELDT Test (Calif English Language Development Test)? ❑ **Yes** ❑ **No** ❑ **I don't know**

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

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

❑ In a single family permanent residence (house, apartment, condo, mobile home)
❑ Temporarily doubled-up (sharing housing with other families/individuals due to economic hardship or loss) (120)
❑ In a shelter or transitional housing program (100)
❑ In a motel/hotel (110)
❑ Unsheltered (car/campsite) (130)

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

❑ Father ❑ Mother ❑ Both ❑ Step-Father ❑ Step-Mother ❑ Guardian ❑ Foster/Group Home ❑ Other _____
Is the above (checked) person (s) the student's LEGAL guardian? ❑ Yes ❑ No If No, please complete a "Caregiver Affidavit"
If there is a legal custody agreement regarding this student, please check one: ❑ Joint Custody ❑ Sole Custody ❑ Guardian

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

1. ❑ Father ❑ Step Father/Guardian (check one) **Full Name:** _____

Employer: _____ **Military?** ❑ Yes ❑ No

2. ❑ Mother ❑ Step Mother/Guardian (check one) **Full Name:** _____

Employer: _____ **Military?** ❑ Yes ❑ No

PLEASE LIST OTHER CHILDREN LIVING AT HOME:

First and Last Name	Relationship	School	Grade	Date of birth

MOST RECENT SCHOOL ATTENDED:

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

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

Signature of Parent/Guardian: Date:

BELOW FOR SCHOOL USE ONLY

Proof of Birth: Type: _____ Verified by: _____	Proof of Residence: Type: _____ Verified by: _____	Proof of Immunization: Type: _____ Verified by: _____	Enroll Date: Enter Date:	Cumulative record requested: _____	Copies to: PSS _____ EL Office _____ Special Ed _____	Grade Placement Verification:

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THE FORM (REV 7/17)

Student Last Name: First Name: Permanent ID:

MAPLE SCHOOL DISTRICT

DISTRICT OF CHOICE & INTERDISTRICT AGREEMENT

STUDENT ATTENDANCE & BEHAVIORAL CONTRACT 2023 – 2024

Date: _____ **Student Name:** _____ **Date of Birth**_____

Grade in School: _____ **Parents/Guardian:** _____

Address: _____ **Phone:** _____

1. Attend Maple School daily and report to all classes on time. If absent due to illness, call the school by 8:30 A.M. The Superintendent may request a doctor's verification after 3 days absent. After 10 days absent, 3 or more unexcused lates or early outs, the DOC or Inter-District Transfer may be revoked.
2. Maintain a 2.0 or "C" grade point average in ***all*** subjects/classes.
3. Follow ***all*** School/District policies and rules while on school grounds, going to or coming from school, at school activities, or using district transportation.
4. Exhibit appropriate and respectful conduct towards staff. Refrain from Prohibited Student Conduct while on school grounds, going to or coming from school, at activities, or using district transportation. Prohibited student conduct includes, but is not limited to Board Policies outlined in BP 5131.
5. Refrain from any conduct that could result in suspension or expulsion as described in Education Code Section 48900.
6. Refrain from off-campus conduct during nonschool hours which poses a threat or danger to the safety of students, staff, or district property, or substantially disrupts school activities.
7. Parents will provide an up-to-date phone number in order to reach the parent during all school hours.
8. Parent will provide own transportation.

If ***any*** part of this agreement is not fully complied with, enrollment in Maple School District may be revoked by the Superintendent pursuant to Board Policy/Administrative Regulation 5117. Parents shall be notified of non-compliance in writing or by conference prior to revoking enrollment.

Review System:

1. *Grades will be reviewed every quarter by teacher progress reports and/or quarter/semester grades for the length of the contract.*
2. *Attendance will be reviewed weekly via computer printout for the length of the contract.*
3. *Behavioral/discipline incidents will be reported immediately to the Superintendent and Parents.*

By signing below, I acknowledge that I have read and agree to the terms of this agreement. The term of this agreement is from date of signature until my child's 8th grade graduation from Maple School

_____ _____ _____ _____

Student's signature *Date* *Parent's signature* *Date*

_____ _____

Superintendent/Designee *Date*

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.

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

State of California—Health and Human Services Agency

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

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)	/ /
Pruebas con Tuberculina (Mantoux/PPD)	/ /
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					
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)

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

Nombre, domicilo, y teléfono del examinador

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: ▫ 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.

AUTHORIZATION FOR ANY MEDICATION TAKEN DURING SCHOOL HOURS

Valid ***only*** for the current school year.

Part 1: To be completed by Parent or Legal Guardian

Note: All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child's name, name of the medication, dosage, method of administration, and name of Physician.

I request that designated school personnel assist my child in taking this prescribed medication (including prescribed over-the-counter medication). I understand that my child may not have nor take medication at school unless all requirements are met. I hereby give consent for a School Nurse or District Administrator to communicate with my child's Physician and school personnel as needed with regard to this medication.

_____ M F _____ _____

Child's Name Sex Birthdate ID#

_____ _____ _____

Name of School Grade Teacher Room Number

I have read and understand the 'Notice of Provisions' printed below. I will ***immediately*** notify the school if there are any changes in medications my child is taking at school.

_____ X _____ ( ) _____ ( ) _____ ( ) _____

Date Parent or Legal Guardian Signature Home Phone Work Phone Emergency Phone

Please review the **'Notice of Provisions' California Education Code (CEC) Sections 49423, 49480** and **California Administrative Code (CAC) Title 5, 18170,** listed below.

California Education Code, Section 49423 – Administration of prescribed medication for pupil

Notwithstanding the provisions of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated personnel if the school district receives:

1. A written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken, and
2. A written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in matters set forth in the physician's statement.

California Education Code, Section 49480 – Continuing medication regimen for nonepisodic condition; required notice to school employees

The parent or legal guardian of any public school pupil on a continuing medication regimen for a nonepisodic condition shall inform the school nurse or other designated certificated school employee of the medication being taken, the current dosage, and the name of the supervising physician. With the consent of the parent or legal guardian of the pupil, the school nurse may communicate with the physician and may counsel with the school personnel regarding the possible effects of the drug on the child's physical, intellectual, and social behavior, as well as possible behavioral signs and symptoms of adverse side effects, omission, or overdose. The superintendent of each school district shall be responsible for informing parents of all pupils of the requirements of this section.

California Administrative Code Title 5, 18170 – The agency shall follow these provisions pertaining to medication

1. An assigned staff member shall administer medications prescribed by a physician for a child provided written parental consent has been given.
2. Record of medication dosages to the child and date and time medication is administered shall be maintained by the facility.
3. Centrally stored medicines shall be kept in a safe and locked place that is not accessible to persons other than employees responsible for health supervision. Each container shall carry the name of the medication, the name of the person for whom prescribed, the name of the prescribing physician and the physician's instructions. All centrally stored medications shall be labeled and maintained in compliance with State and Federal laws. Each person's medication shall be stored in its originally received container.

   No medications shall be transferred between containers. The agency shall be responsible for assuring that a record of centrally stored prescription medications for each person in care includes: the name of the person for whom prescribed, the drug name, strength and quantity, the date filled, the prescription number and name of issuing pharmacy.
4. All medications shall be centrally stored in an area which is totally inaccessible to children.

****Procedures under the Individualized Education Program (IEP), Individualized Health Program (IHP) or 504 Plan should not be addressed on this form. Please request form for Specialized Physical Health Care Services pursuant to California Education Code Section 49423.5.**

(See reverse)

Part 2: To be completed by the Physician

The child named below is under my care. It is necessary for him or her to receive the following medication during school hours.

Name of Child (Print)_____

Diagnosis for which medication is prescribed_____

Name of medication (one medication per form)_____

Dosage (Be specific, i.e., milligrams, etc.) _____

Time of day to be given _____ **Frequency if 'as needed'**

If 'as needed' describe indications and sequence orders_____

Method of administration: ORAL ~ Liquid ~ Tablet ~ Inhaler **DROPS** ~ Eye R L ~ Ear R L ~ Nostril R L

Topical ~ Other ~ _____

Precautions, reactions, or side effects _____

For Severe Allergy: If the following symptoms occur (check appropriate):

~ choking ~ hives ~ skin rash ~ swelling (eyes and lips) ~ loss of voice ~ breathing difficulty

~ loss of consciousness ~ other _____

Use: (circle one) Epi-pen Jr. or Epi-pen

~Transport student to nearest emergency room

Storage and Handling ~ Routine handling, medications in locked storage and administered by authorized school personnel

~ 72 hour disaster supply only ~ Refrigeration

If Medically Necessary ~ Child to carry, school personnel to administer ~ Child trained to carry and self-administer (medicate)

Additional special instructions/interventions_____

_____

Physician (Printed Name) Date Signature

_____ _____ _____

Office Address Office Phone Office Fax

*****SCHOOL STAFF: Notify school nurse or district administer if allergy or asthma is indicated under diagnosis.**

(See reverse)