

## Enrollment Checklist

- Enrollment form (completed)
- Copy of birth certificate
- Immunization record
- Transcript if 10th-12th grades **or** 8th grade report card
- Utility bill (students who reside in Simi Valley) **or**  
Interdistrict Permit (students who live outside of Simi Valley)



# SIMI VALLEY UNIFIED SCHOOL DISTRICT ENROLLMENT FORM

BC \_\_\_\_\_  
UB/IDP \_\_\_\_\_  
IMM \_\_\_\_\_  
RR \_\_\_\_\_

(PLEASE DO NOT WRITE OR TYPE IN SHADED AREAS)

Student ID   
School

Sp. Ed. Code

Entry Date

## Student Information (PLEASE PRINT)

Legal Last Name \_\_\_\_\_ Suffix \_\_\_\_\_ (Jr., Sr., etc.)

Legal First Name \_\_\_\_\_ Legal Middle Name \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Non-Binary \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Birth City \_\_\_\_\_ Birth State \_\_\_\_\_ Birth Country \_\_\_\_\_

## Primary Residence

Street Address \_\_\_\_\_ Unit # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Mailing Address (if different than primary residence)

Street Address or P.O. Box \_\_\_\_\_ Unit # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Student Mobile Phone # (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
(If applicable)

Parent/Guardian \_\_\_\_\_ Primary Telephone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### Is the student's ethnicity Hispanic/Latino?

- Yes
- No

The above part of the question is about ethnicity, not race. *No matter what you selected above, please answer the section to the right* by marking one or more boxes to indicate what you consider the student's race to be.

### What is the student's Race? (Please check all that apply)

- |                           |                                       |   |
|---------------------------|---------------------------------------|---|
|                           | <u>Asian</u>                          | <u>Pacific Islander</u>                         |
| Alaskan / Native American | <input type="checkbox"/> Chinese      | <input type="checkbox"/> Hawaiian               |
| Black / African American  | <input type="checkbox"/> Japanese     | <input type="checkbox"/> Guamanian              |
|                           | <input type="checkbox"/> Korean       | <input type="checkbox"/> Samoan                 |
| Caucasian / White         | <input type="checkbox"/> Vietnamese   | <input type="checkbox"/> Tahitian               |
|                           | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Other Pacific Islander |
|                           | <input type="checkbox"/> Laotian      |   |
|                           | <input type="checkbox"/> Cambodian    |   |
|                           | <input type="checkbox"/> Other Asian  |   |
|                           | <input type="checkbox"/> Filipino     |   |
|                           | <input type="checkbox"/> Hmong        |   |

Student's Communication Language: English or Spanish  
(CorrLng)

Has your child attended SVUSD schools previously?  No  Yes Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## LAST SCHOOL STUDENT ATTENDED:

School Name \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

School Address \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

District Enter Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

School Enter Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

**(Please indicate only one language per line):**

1. Which language did your child learn when he/she **first** began to talk? \_\_\_\_\_  
(First)
2. What language do you use **most frequently** to speak to your child? \_\_\_\_\_  
(Primary)
3. What language does your child **most frequently** use at home? \_\_\_\_\_  
(at Home)
4. What language **is most often spoken by adults** in the home? \_\_\_\_\_  
(by Adults)

**Date student first attended any public school in the U.S.**    \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Date student first attended any public school in California**    \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Residence:** Where is your child/family currently living?

Please check appropriate box:

- In a single family permanent residence (house, apt., condo, mobile home)
- Doubled-Up (sharing housing with other families/individuals due to economic hardship or loss)
- In a shelter or transitional housing program
- In a motel/hotel  
    Unsheltered (car/campsite)
- Other (please specify): \_\_\_\_\_

**SPECIAL PROGRAMS:**

**Special Education**

Has your child qualified for a Special Education Program?     No     Yes    If yes, please provide a copy of the IEP  
( \_\_\_\_ Resource (RSP)    \_\_\_\_ Special Day Class (SDC)    \_\_\_\_ Speech/Language)

**504 Plan**

Does your child have a 504 Plan?     No     Yes:    If yes, please provide a copy of the 504 Plan

**G.A.T.E.**

Has your child qualified for the G.A.T.E.(Gifted) Program?     No     Yes

<b>SIBLINGS:</b>			Birth Date	Name of Current School
_____	_____	_____	____ / ____ / ____ mo./day/year	_____
Last	First	Middle		
_____	_____	_____	____ / ____ / ____ mo./day/year	_____
Last	First	Middle		
_____	_____	_____	____ / ____ / ____ mo./day/year	_____
Last	First	Middle		
_____	_____	_____	____ / ____ / ____ mo./day/year	_____
Last	First	Middle		
_____	_____	_____	____ / ____ / ____ mo./day/year	_____
Last	First	Middle		

**Student Guardianship Status:**  Parent/Legal Guardian  Foster Family  Licensed Children's Inst.  
 Foreign Exchange  Other: \_\_\_\_\_

*If a custody agreement exists, it is the responsibility of the Parents/Legal Guardians to provide the school with a copy of the agreement. In the absence of a legally binding agreement, the Parents/Legal Guardians listed will be presumed to have full and equal custodial rights.*

*For students in Foster Care or LCI Placement: The student's foster parent or case manager must supply a copy of the Court Findings and Orders.*

**PARENT/GUARDIAN:**

**Parent/Guardian #1:**

Mother  Father  Other: \_\_\_\_\_

Does the student live with this Contact?  Yes  No Communication Language \_\_\_\_\_

**Parent Education:**  Graduate Degree or Higher  College Graduate  High School Graduate  Not a High School Graduate  Some College or Associates Degree  
(CorrLng)

**Name:** Last First Primary Number:  
( ) --

**Mailing address if different from primary residence:** Work Number: Ext.  
( ) --

Street City State Zip Mobile Number:  
( ) --

E-Mail Address: \_\_\_\_\_

**Parent/Guardian #2:**

Mother  Father  Other: \_\_\_\_\_

Does the student live with this Contact?  Yes  No Communication Language \_\_\_\_\_

**Parent Education:**  Graduate Degree or Higher  College Graduate  High School Graduate  Not a High School Graduate  Some College or Associates Degree  
(CorrLng)

**Name:** Last First Primary Number:  
( ) --

**Mailing address if different from primary residence:** Work Number: Ext.  
( ) --

Street City State Zip Mobile Number:  
( ) --

E-Mail Address: \_\_\_\_\_

**EMERGENCY CONTACTS:**

**Emergency Contact #1**

Type:  Relative \_\_\_\_\_ (relationship to student)  
 Friend  Babysitter  Other: \_\_\_\_\_

**Name:** Last First Primary Number:  
( ) --

**Emergency Contact #2**

Type:  Relative \_\_\_\_\_ (relationship to student)  
 Friend  Babysitter  Other: \_\_\_\_\_

**Name:** Last First Primary Number:  
( ) --

**Emergency Contact #3**

Type:  Relative \_\_\_\_\_ (relationship to student)  
 Friend  Babysitter  Other: \_\_\_\_\_

**Name:** Last First Primary Number:  
( ) --

## Student Medical History

Student Name: \_\_\_\_\_

Student Id: \_\_\_\_\_

**No on-going health problems or concerns:**

	Please mark boxes and specify as needed: Health Problem(s)	Medication(s) for this Problem	Taken at Home	**Taken at School
<input type="checkbox"/>	Emotional/Mental Health Concerns		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	ADD/ADHD		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Autism Spectrum Disorder		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Anaphylaxis/Epi-Pen		<input type="checkbox"/>	<input type="checkbox"/>
	Allergy, nuts <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		<input type="checkbox"/>	<input type="checkbox"/>
	Allergy (other) <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Specify:		<input type="checkbox"/>	<input type="checkbox"/>
	Asthma <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Neurological Impairment		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Respiratory Condition		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes, Type I		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes, Type II		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Lactose Intolerance		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cerebral Palsy		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Migraine and other headaches		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Digestive Problems		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Seizures		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Immune System Abnormalities		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Adverse Drug Reaction		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hearing Concerns		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Speech Difficulty		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Congenital/Birth Abnormalities		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Scoliosis		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart Disease		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Vision Concerns – Glasses/Contacts		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Oncology (Cancer) Condition		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Organ Transplant		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Concussion		<input type="checkbox"/>	<input type="checkbox"/>
<b>Other current health problems:</b>				
<b>List Physical Health Care Needs at School (excluding medications) i.e., wheelchair, G-tube feedings, nebulizer, etc.:</b>				
<b>** For a student to take medication at school during the school day the “Request for Medication to be Taken During School Hours” form must be completed by Physician and parent.</b>				

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date