CHUALAR SCHOOL ELEMENTARY
STUDENT INFORMATION

Grado ______ Maestro ______ Fecha matriculado ______

2024-2025

lombre del estudiante: ______________________ Fecha de Nacimiento ______
Apellido Nombre

lasculino ☐ Femenino ☐ Edad: ______ Lugar de Nacimiento: Ciudad ______ Estado: ______ Pais: ______

omicilio Fisíco: ______ Ciudad: ______ Estado: ______ Zona postal ______

omicilio Postal/PO Box: ______ Ciudad: ______ Estado: ______ Zona postal: ______ Teléfono: ______

ontacto de emergencia: ______ Teléfono: ______

ontacto de emergencia: ______ Teléfono: ______

ialud, medecina
problemas alergicos: ______ Doctor/ Hospital: ______ Teléfono: ______

dioma (s) que habla su hijo(a): ______ Idioma(s) que se habla(n) en casa: ______

l estudiante ha estado matriculado en las escuelas de California desde (año): ______ El estudiante ha sido alguna vez expulsado de la escuela? ☐Yes ☐ No

les y año en que fue matriculado en los E.U: ______ Alguna vez ha recibido su niño(a) Educación Especial? ☐ Yes ☐ No

Jltima escuela que asistio: ______ Domicilio: ______ Ciudad/Estado/Zona postal: ______

in caso de una emergencia debido a enfermedad o accidente, cuando no se nos pueda localizar, las autoridades escolares tienen nuestro permiso para usar su mejor uicio en el interés de la salud de nuestro estudiante. Entendemos que la escuela no asume responsabilidad finaciera por atención médica o la transportación en mbulancia en caso de emergencia. Si ☐ No ☐

'o he leído y entendido la póliza del uso de la Red de comunicaciones y del uso de las computadoras por lo tanto yo doy mi permiso para que mi hijo/a utilice las omputadoras y tenga acceso al uso de la red de comunicaciones (Internet) Si ☐ No ☐

Ie recibido el aviso de los derechos y responsabilidades de los padres. Si ☐ No ☐

/li hijo/a tiene mi permiso de participar en excurciones, programas de después de escuela y actividades de la escuela. Si ☐ No ☐

HERMANOS Y HERMANAS

lombre/Apellido	Fecha de Nacimiento	Grado	Nombre/Apellido	Fecha de Nacimiento	Grado

INFORMACION DE PADRE

☐ Padre/guardian trabaja en la agricultura, procesamiento de alimentos frescos, forestal o pesca comercial y tiene que mudarse por razones de trabajo.

dre/Guardian: ______

ve con el estudiante? ______ Si ______ No
mero de telefono : ______
ıpleador: ______

ección de Negocio: ______

éfono de Negocio: ______

Nivel Educativo del Papá

No es graduado de la secundaria ____Graduado de la Secundaria
Algo de Colegio ____Graduado del Colegio
Capacitación de postgraduados

Madre/Guardian: ______

Vive con el estudiante? Si ______ No
Numero de telefono : ______
Empleador: ______

Dirección de Negocio: ______

Teléfono de Negocio: ______

Nivel Educativo de la Mamá

____No es graduado de la secundaria ____Graduado de la Secundaria
____Algo de Colegio ____Graduado del Colegio
____Capacitación de postgraduados

ertifico con mi firma que toda la información dada anteriormente es correcta segun mi conocimiento.

a del Padre/Guardian: ______ Fecha: ______

CHUALAR UNION ELEMENTARY SCHOOL DISTRICT

PERMANENT RECORD
DO NOT REMOVE

HOME LANGUAGE SURVEY

DATE SCHOOL TEACHER ROOM NUMBER

The California Education Code required schools to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students. Your cooperation in helping us meet this important requirement is requested.

Student name: Last First Middle Grade Birthrate

1. Which language did you child learn when he/she first began to talk? ______
2. What language does your child use most frequently at home? ______
3. What language do you use most frequently to speak to your child? ______
4. Name the language most often spoken by the adults at home. ______
5. Where was your child born? Country:______ State:______ City: ______
6. Month and year that student entered the U.S. ______ / ______ (month / year)
7. Month and year that the student first entered a U.S.A School ______ / ______ (month / year)

Signature of Parent or Guardian Date

NOTE: When you indicate a language other than English, we are legally required to test your child's English language proficiency. You will be notified of the results of that test.

************FOR OFFICE USE ONLY ************

(Indicate L or F) English EO------

School	Date	Grade	Score	LEP	FEP
			1 2 3 4 5 6		
			1 2 3 4 5 6		
			1 2 3 4 5 6		
			1 2 3 4 5 6		
			1 2 3 4 5 6		
			1 2 3 4 5 6		

Spanish

School	Date	Grade	Score	LEP	FEP
			1 2 3 4 5 6		
			1 2 3 4 5 6		
			1 2 3 4 5 6		
			1 2 3 4 5 6		
			1 2 3 4 5 6		
			1 2 3 4 5 6		

Re-designation Date______ Follow-up Date______

Chualar Union Elementary School District

24285 LINCOLN STREET • CHUALAR, CA 93925 • PHONE: 831.679.2504 • FAX: 831.679.2071

Ethnicity and Race Student Information Form
Información Étnica y Racial de Estudiante

Student Name / *Nombre del Estudiante*: ______________________________
Grade / *Grado:*__________ Birthdate / *Fecha Natal* (m-*mes*)______ (d-*día*)______ (yyyy/*año*)______
School Name / *Nombre de la Escuela:*______________________________

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

☐ **Not Hispanic or Latino**
☐ **Hispanic or Latino** (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

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 child's race to be.

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

☐ **Native Indian of the Americas or Alaskan Native (100)** (A person having origins in any of the original peoples of North or South America (including Central America), and who maintains tribal affiliation or community attachment.)
☐ **Asian (200)** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
☐ **Native Hawaiian or Pacific Islander (300)** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
☐ **Black or African American (600)** (A person having origins in any of the black racial groups of Africa.)
☐ **White (700)** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

For the 2009/10 school year, school districts in California are required to follow the new standards on collecting individual-level race and ethnicity data as specified by the U.S. Department of Education (ED).

¿CUAL ES EL ORIGEN ETNICO DE SU NIÑO(a)? Marque uno:

☐ **NO Hispano o Latino**
☐ **Hispano o Latino** (una persona de cultura u origen cubano, mexicano, puertorriqueño, sudamericano, o centroamericano, sin importar su raza)

Este punto arriba trata sobre la etnia, no la raza. No importa cuál haya seleccionado en la pregunta de arriba, **por favor continúe respondiendo a lo siguiente** marcando uno o más de las cajas para indicar lo que usted considere es la raza de su niño(a).

¿CUÁL ES LA RAZA DE SU NIÑO(a)? (Puede hacer hasta 5 selecciones)

☐ **Indio Nativo del las Americas o Nativo de Alaska (100)** (Una persona de origen de cualquier pueblo original de Sudamérica o Norteamérica [incluyendo Centroamérica], quien mantiene afiliación a su tribu o vínculo a su comunidad.)
☐ **Asiático (200)** (De origen de cualquier pueblo original del Lejano Oriente, Asia del Sur, o el Subcontinente de la India, incluyendo, por ej., Cambodia, China, India, Japón, Corea, Malasia, Pakistán, las Islas Filipinas, Tailandia, y Vietnam.)
☐ **Hawaiano o Isleño del Pacifico (300)** (De origen de cualquier pueblo original de Hawaii, Guam, Samoa Norteamericana, u otras Islas del Pacifico.)
☐ **Negro o Afroamericano (600)** (Una persona con orígenes en cualquier grupo de raza negra de África.)
☐ **Anglosajón (700)** (De origen en cualquier pueblo original de Europa, Medio Oriente o Norte de África.)

STUDENT RESIDENCY QUESTIONNAIRE/AFFIDAVIT

This document is intended to address the McKinney-Vento Assistance Act. Your answers will help determine documents necessary to enroll your child quickly.

Student: ____ (M/F)

Birthdate: ________________ Grade:_____________

1. Do you and your student live in a fixed, regular, adequate nighttime residence? ***Yes*** ***No***
(If you circled "Yes", stop here. You must provide a gas or electric bill in your name as proof of residence. If you circled "NO", please continue with this form.)

2. Do you and the student live in:
   - ☐ shelter
   - ☐ motel/hotel
   - ☐ temporarily with another family in a house, mobile home, or apartment
   - ☐ in a car or RV
   - ☐ at a campsite
   - ☐ transitional housing
   - ☐ other location ____

3. The student lives with:
   - ☐ one parent
   - ☐ two parents
   - ☐ a qualified relative
   - ☐ friend(s)
   - ☐ an adult that is not the legal guardian
   - ☐ alone with no adult(s)

4. I am:
   - ☐ the parent/legal guardian of the above-named student
   - ☐ a qualified adult relative of the above-named student
   (Relationship: _______________________________)

I declare under penalty of perjury under the laws of this state that the information provided here is true and correct and of my own personal knowledge.

Signature: ____ Date: __________

Print Your Name: ______________________________________

Residence:

____
Street City Zip

Mailing Address:

____
Street City Zip

Telephone #: (   ) ____________________ Cell Phone #: (   ) ___________________

Chualar *Union Elementary School District*

HEALTH INFORMATION REPORT

HEALTH DATA is very important. Your information is confidential.

PLEASE PRINT

CHILD'S NAME: ______________________________ (Last) ______________________________ (First) ____________ (MI)

Date of Birth: ____________ Boy ________ Girl ____________ Birthplace ____________

Address ____ Zip Code ____________

Home Phone ______________________

Name of Last School Attended ____

City ______________________ State ______________ Zip Code ____________

Relationship to Child (Circle)	Name of Person	Check if Living with Student
Father / Stepfather		
Mother / Stepmother		
Guardian		
Brothers	D.O.B.	
Sisters	D.O.B.	

PLEASE ANSWER **YES** or **NO** TO THE FOLLOWING. IF YOU ANSWER YES ON ANY OF THE QUESTIONS, PLEASE EXPLAIN IN MORE DETAIL.

- ______ Was child a normal 9 month pregnancy?
- ______ Were there any complications during pregnancy or birth? ____________
- ______ Birth Weight ____________
- ______ Does child have allergies? ____________
- ______ Does child have asthma? ____________
- ______ Does your child take any medication? ____________ (Written permission signed by a doctor and parent is needed if given at school)
- ______ Does child wear glasses, contacts? ____________
- ______ Does child have/has had frequent ear infections? ____________
- ______ Does child have/has had ear tubes? ____________
- ______ Does child have any hearing problem? ____________
- ______ Does child have any speech problem? ____________
- ______ Does child have heart problem? ____________
- ______ Has child ever had seizures? ____________
- ______ Does child have dental problems? ____________
- ______ Does child have any curvature of the spine? ____________
- ______ Has child had surgery? ____________
- ______ Does child have bowel problems? ____________
- ______ Does child have urinary problems? ____________
- ______ Does child have coordination problems? ____________
- ______ Does child have any serious medical problem not already listed? ____________

Please list any other concerns you may have: ______________________________

____

____

____

____________ Date ______________________ Signature ______________________ (indicate relationship to Student)

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. Th 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 healt 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

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)	Visible Decay Present:	Treatment Urgency:
	Yes ☐ No ☐	Yes ☐ No ☐	☐ 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.

Recopilación de datos de los ingresos del hogar – Formulario de muestra 4 Chualar Union School District 2023-2024 (Rev.4/15)

SECCIÓN I: Proporcione la siguiente información acerca del estudiante que vive en su hogar

APELLIDO	PRIMER NOMBRE	FECHA DE NACIMIENTO (MM / DD / AA)
		/ /

ESCUELA (Escriba "Ninguna" si no asiste a la escuela)	GRADO	AULA	CÓDIGO DE ESCUELA
			6026082

SECCIÓN II: Proporcione la siguiente información acerca de la cantidad de integrantes y los ingresos del hogar

Vea la información adicional en el reverso de este formulario para obtener ayuda para determinar la cantidad de integrantes y los ingresos anuales de su hogar.

1. **Encierre en un círculo la cantidad total de adultos y niños que viven en su hogar:**

   Elija uno: 1 2 3 4 5 6 7 8 9 10 Otra ______

2. **Total de ingresos anuales del hogar: $**

SECCIÓN III: Información y firma del padre o tutor

Certifico (prometo) que la información que proporciono en este formulario es verdadera y que he incluido todos los ingresos. Entiendo que la escuela podría recibir fondos federales y estatales basados en la información que proporciono y que dicha información podría estar sujeta a revisión.

Firma del miembro de la familia adulto que llenó este formulario	**Nombre en letra de molde del miembro de la familia adulto que llenó este formulario**	**Fecha**

NÚMERO DE TELÉFONO DE CASA	NÚMERO DE TELÉFONO CELULAR	DIRECCIÓN DE CORREO ELECTRÓNICO

La información que se presenta en este formulario es un registro académico confidencial y por lo tanto está protegida por todas las leyes de confidencialidad federales y estatales que conciernen a los registros académicos incluyendo, entre otros, la Ley de Confidencialidad y Derechos Educativos de la Familia (FERPA) de 1974, en su forma enmendada (artículo 1232g del título 20 del Código de los EE.UU. [U.S.C.]; parte 99 del título 34 del Código de Reglamentos Federales [CFR]); el título 2, división 4, parte 27, capítulo 6.5 del Código de Educación de California (California Education Code), comenzando en la sección 49060 y siguientes.; la Ley de Prácticas Informativas de California [California Information Practices Act] (sección 1798 y siguientes del Código Civil de California [California Civil Code]) y el artículo 1, sección 1 de la Constitución de California.